REPORT OF THE MEDICAL OFFICER OF HEALTH
C. RICHARD GRAINGER, M.B. Ch.B., M.F.P.H.M., D.P.H., D.Obst.R.C.O.G.
FOR THE YEAR 1989

Presented to the States on 23rd October, 1990
by the Public Health Committee

STATES OF JERSEY

STATES GREFFE

250

1990

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**Seconded by the Family Nursing Services (Jersey) Incorporated.*

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INTRODUCTION

To the President and Members of
the
Public Health Committee

Mr. President, Ladies and Gentlemen; I have pleasure in submitting my Annual Report for 1989.

HIV Infection and AIDS

The inexorable progression of HIV infection to AIDS showed that Jersey patients were following a very similar pattern to that found in the rest of north-western Europe. Few reports of new cases of HIV infection were received in 1989, but it would be premature to assume from this that the incidence of new infections is falling or that the number of people potentially at risk of acquiring the disease is reducing in any significant way.

There was intense public interest in the disease in the first few months of 1989, although interest unfortunately waned towards the end of the year. HIV infection and AIDS will continue to create problems for us for the foreseeable future.

A number of issues pertaining to care, ethics, legality and morality have been addressed during the year, but there will be a continuing need to review the situation as our understanding of the disease and its implications becomes clearer.

Health Promotion

As a direct consequence of the concern over HIV infection and AIDS a positive decision was taken to review health education and promotion within Jersey. Prior to the review, there had been many discrete areas of health education whilst the Health Education Unit within the Public Health Committee's control for many years, had had a principal role as a resource centre. The review of health promotion concluded that an integrated multi-sectorial approach should be used. In the first instance a Health Education Strategy Group was formed, involving elected members of the Public Health and Education Committees and senior officers of both Committees.

A Clinical Care Team was set up to review all aspects of the care of people with HIV infection or AIDS, or people who may be at risk or suspect that they may be at risk. Wherever the Clinical Team felt there were deficiencies in the service, they were to report to the Public Health Committee so that appropriate developments in service could be undertaken.

One area of concern in health promotion was the ability to put over the messages of health promotion in a meaningful way. Jersey has a very effective communications network, involving radio, television and newspapers. Representatives of the three media were invited to join officers of the Public Health and Education Committees in a Communication Group with a view to advising the Health Education Strategy Group on how to communicate messages to the general public or specific sectors of the public and, wherever possible, to communicate the policies of the Health Education Strategy Group in a meaningful way.

Health Life Survey

A Health Life Survey for the States of Jersey was undertaken by Deeks and Campbell of the University of Southampton Medical Statistics and Computing Department. The survey has proved to be a valuable source of information about the smoking, drinking, exercise and eating habits of a wide group of people in Jersey. It provides an excellent baseline against which to measure change in lifestyle status and gives a firm basis for determining further action.

The results of this survey are consistent with the general household census that was carried out at about the same time. Both surveys show that there are lifestyle habits which put people at risk of damaging their health due to everyday activities such as smoking and consumption of inappropriate amounts of alcohol.

Food Poisoning

Unfortunately the prediction that there was a chance that the number of cases of food poisoning in 1989 would be greater than in 1988 proved to be correct. There were large numbers of people affected by food poisoning, in particular due to salmonella enteritidis, phage type 4. The amount of work which had to be carried out by this department in investigating these outbreaks seriously affected other work. If other emergencies had occurred at the same time we would have had serious difficulties in coping.

A major effort was made to put over the message that care in handling, preparation and presentation of food was required. This culminated in a seminar for senior managers in the catering and tourism industry to stress the importance in preparing, during the quiet season, a safe environment for the production of food. We had great co-operation from the catering and tourism industry and from the media, but the crux of the matter is, was the message received? There is good evidence that it was received but, even more important, the recommendations must be implemented with scrupulous attention to detail in the future.

Unless effective action is taken there again arises the potential for large numbers of people to have their health seriously affected and, in the long term, the economy of Jersey could suffer significantly.

There are many resources available in Jersey for training in food hygiene. It is essential that the catering industry moves towards the position where everyone involved in that industry is appropriately trained at the start of their career and updated at suitable intervals.

Standards of Accommodation for Seasonal Workers

Many of the people working in the catering and agriculture industry are seasonal workers. Progress in drawing up standards for their accommodation has been slow. The majority of Committees involved with seasonal workers had agreed standards by the middle of the year but delays were incurred because of the requirement to reach consensus, which meant that progress was determined by the tardy.

Joint Environmental Meetings with Guernsey

During the year an interesting development took place in that the Public Health Committee and the Guernsey Board of Health joined together to form an environmental health group to look at common health problems, with a view to reaching a combined approach on tackling these challenges and to try and maximise the use of available resources and achieve consistency of standards on environmental matters within the Bailiwicks.

The group will have to establish its credibility and usefulness in the first instance but, used correctly, could have an enormous influence for good.

Registered Homes

The draft Residential Homes Law was lodged au Greffe in the middle of the year for debate at a later date. The purpose of this law was to update the Old Person's Homes (Registration) (Jersey) Law, 1964 and to extend the scope for registration to residential homes providing accommodation and care for groups such as those with physical and mental handicap. They would then have the same degree of protection as provided to the elderly under the existing law.

The law was in an enabling form so that appropriate standards could be applied to the disparate groups of homes that would fall within its ambit. The law has been discussed in detail and agreed with the Residential Homes Association and other organisations, who were presently outside the need to register, had agreed that it was desirable that registration and inspection should apply to them.

Community Services

The Public Health Committee's policy is to try and maintain people within the community as far as possible. This resulted in a large amount of attention to community services throughout the year. A review of the Home Help Service took place in 1989 and some of the recommendations in that report were implemented, but it became obvious as the review was taking place that there were implications outside the Home Help Service, in particular with its relationship with the Family Nursing Service. Because of this, some of the recommendations of the review were not implemented but were held over pending a wide-ranging review of the Family Nursing Service which takes place early in 1990.

Review of Social Work

A very important part of the care of people, both in hospital and in the community, is dependent on an adequate social work service. In Jersey there are a number of disparate groups taking on this function and many of these groups and individuals are working in isolation. In the first instance it was decided to gather together all the social workers within the Public Health Committee's control and form a Social Workers' forum. This met on a number of occasions throughout the year and culminated in a report to the Public Health Committee which recommended a wide-ranging review of social work in the Island. This recommendation was accepted but, because of the involvement of several different Committees of the States, the Policy and Resources Committee was asked to initiate that review, which will be undertaken in 1990 with the Public Health Committee taking a lead role. The ultimate intention is to provide an appropriate form of social work adapted to the needs of Jersey.

Tobacco, Alcohol and Drug Addiction

Addiction to smoking, alcohol and drugs continued to cause problems in 1989. It is paradoxical that the amount of concern and effort devoted to the control of these addictions is inversely proportional to the amount of known damage to the health of the population. It was encouraging, however, to note that taxation was raised on cigarettes and alcohol as a health promotion measure. The pattern of smoking disclosed by the lifestyle survey and the household expenditure survey shows a somewhat similar pattern to that of the United Kingdom and highlights the special concern we have over the smoking habits of the young, and particularly young women.

It is estimated that the annual toll of premature deaths in the world caused by tobacco is around three million. By 2025 it is estimated that this will have risen to 10 million premature deaths per year. Many countries have already introduced legislation to ban or curtail tobacco advertising, including tobacco sponsorship of sport. There are certain matters which only legislation can control, but general pressure by customers will go a great way towards controlling smoking in public places such as restaurants.

The Crown Officers drew the attention of everyone to the ease with which drug abusers were able to obtain prescriptions for controlled drugs. It was apparent that some people who were obtaining prescriptions were abusing the substances prescribed by administering them in a way that differed from that recommended by the doctor, and there was further evidence that substances obtained on the licit market were being diverted into the illicit drug scene.

Due attention must be given to the serious warnings that were issued by the Crown Officers over the abuse, misuse and lack of control of these dangerous substances.

The Toll of Accidents

Accidents on the road, in the home and at work, including fishing, kill many people in the young age groups so that many years of productive life are lost, as well as producing significant amounts of morbidity and disability.

The introduction of the Health and Safety at Work Law should go some way to drawing people's attention to occupational health risks and should significantly reduce illness and injury from such risks. Further help in the reduction of accidents, particularly on the road, will be the introduction of the breathaliser early in 1990, which will undoubtedly have an impact on the number of people drinking and driving, as in the other countries in which it is now being used.

The Look After Yourself Scheme

A primary aim of health promotion is to involve individuals in protecting and promoting their own health. In order to do this, people need to have an understanding of the aetiology of disease and the methods available to the individual to protect themselves. In many areas the Look After Yourself scheme has proved to be a useful method for involving people in a pleasurable way in protecting their own health. The first two Jersey trainers have been formally approved and, as a start, it is hoped that they will train up to 20 further trainers during 1990, who will then pass on their knowledge to others at courses set up at suitable venues from the autumn of next year. Given the right support this could be a most effective way of improving the health of interested people in Jersey.

Abortion Figures and Family Planning

In my last Report I brought the attention of the Public Health Committee to the apparent failure of the Family Planning Service of the Island. A total of 287 residents of Jersey travelled to the United Kingdom for abortions during 1987 and, unfortunately, in 1988 the number was even higher, being 313. Even more distressing was the fact that the number of women aged under 19 who had abortions had risen from 43 in 1987 to 65 in 1988.

There was a large increase in those aged between 25 and 29 — the numbers in 1987 being 67 increasing to 80 in 1988. The only age group in which there was a decline in numbers was those aged 35 and over. Because the statistics from the U.K. are a year behind the current year, we will not be able to judge whether any campaign to increase the uptake of family planning has been effective until 1992 at the earliest, if we take a reduction in the number of abortions being undertaken in the U.K. as a measure of success.

Toxic Hazards in the Environment

The increasing availability of lead-free petrol is to be welcomed as it will make a contribution to the improvement of the environment. This should not lull people into a false sense of security in thinking that lead poisoning is unlikely to occur in Jersey. The only proven case of lead poisoning during the year was a man exposed to lead because of his particular hobby. We should remember that much of the water not supplied by the Jersey New Waterworks Company is acidic, and lead piping in the water supply could lead to potentially toxic levels of lead in a domestic setting. Indiscriminate exposure to lead in an occupational setting could also cause problems.

Rarely is there one simple method for the control of toxic hazards in the environment. There must be vigilance in monitoring the quality of our environment to ensure that we are not unwittingly exposed to hazards.

Health Hazards in Travelling Abroad

One hazard to which many people from Jersey are exposed is that of international travel. We frequently see people returning to the Island suffering from food poisoning and other infections. There are a number of precautions which can be taken before departure, including immunisation against a wide range of infectious diseases.

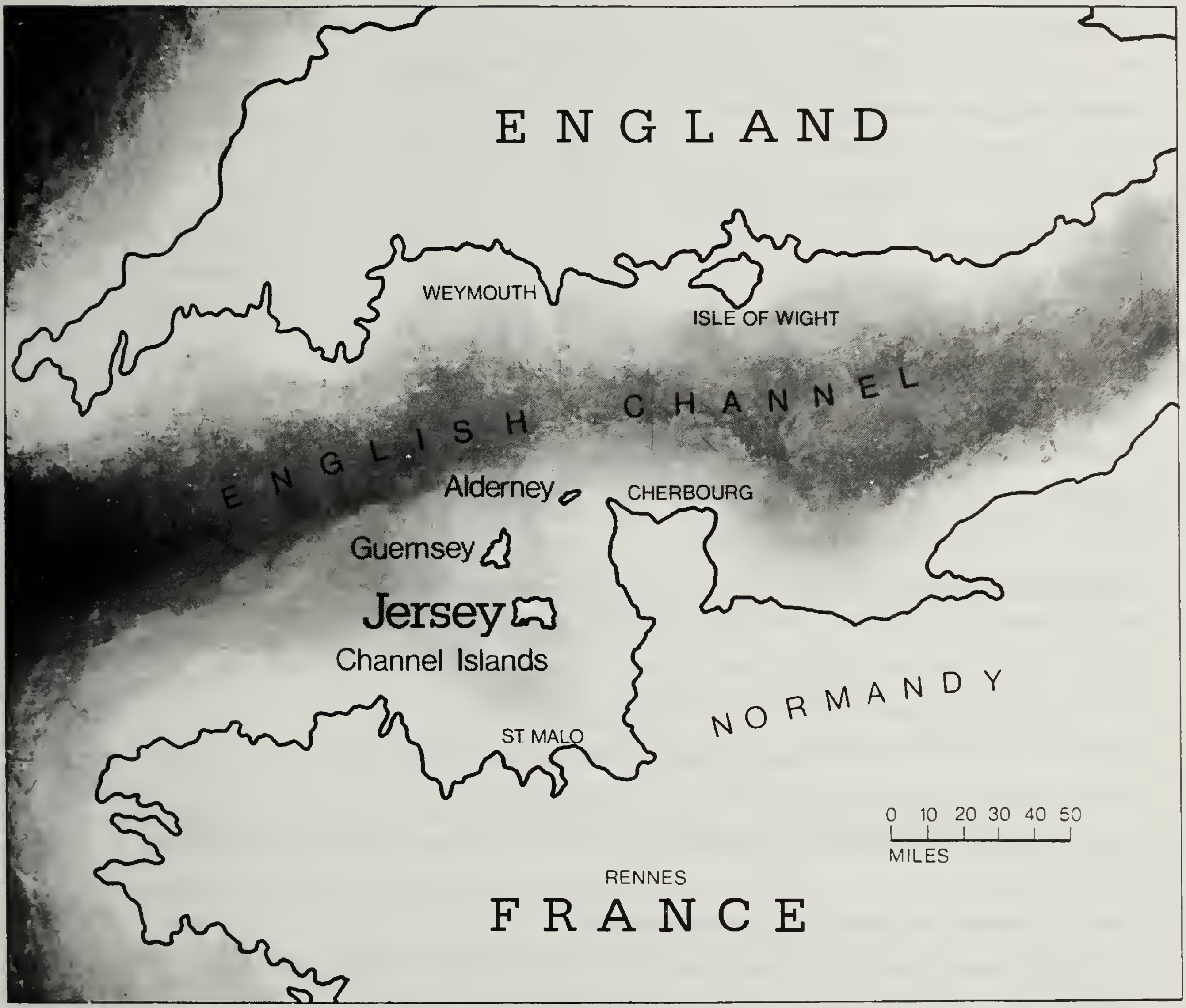
Advice is available from general practitioners or from the Immunisation Clinic held regularly at the Health Centre of the General Hospital. It is essential, however, that people contemplating travel overseas where immunisation is required or recommended should allow sufficient time for the course of immunisation to be carried out. Early appointments are therefore recommended.

Thanks

In conclusion I would wish to extend my sincere thanks to the President and members of the Public Health Committee for their interest and support of the work of the Public Health Department.

I would also wish to record my appreciation of the constant support provided by all members of the department throughout 1989.

C.R. Grainger
Medical Officer of Health



Jersey & Channel Islands in Relation to
England & France

I
STATISTICAL SUMMARY

VITAL STATISTICS

Area (acres)	28,717
Population (estimated year-end resident)	82,750
Number of persons per acre	2.8
Marriages	651
Marriage rate (persons married in 1989 per 1,000 estimated population)	15.73
Deaths (excluding visitors to the Island)	827
Deaths of visitors in the Island	69
Death rate per 1,000 estimated population	10.00
Comparability factor	0.97
Standardised death rate	9.7
Live births	1,074
Live birth rate per 1,000 estimated population	13.0
Illegitimate live births	170
Illegitimate live births per cent of total live births	15.8
Stillbirths	2
Stillbirth rate per 1,000 live and stillbirths	1.9
Total live and stillbirths	1,076
Infant deaths	4
Infant mortality rate per 1,000 live births (total)	3.7
Infant mortality rate per 1,000 live births (illegitimate)	0.9
Neo-natal mortality rate (first four weeks) per 1,000 live births	2.8
Early neo-natal mortality rate (first week) per 1,000 live births	2.8
Peri-natal mortality rate (stillbirths plus deaths during first week) per 1,000 live and stillbirths	4.6
Maternal deaths	—
Maternal mortality rate per 1,000 live and stillbirths	—
Malignant disease (cancer) (all forms) mortality rate per 1,000 estimated population	2.69
Tuberculosis (all forms) mortality rate per 1,000 estimated population	—

TABLE I — 1

Area of Jersey and population by individual parishes — Census 1989

Parish	Acres	Square Miles	Square Kilometres	Population	Population Density*
Grouville	1,935	3.0	7.8	4,173	533
St. Brelade	3,157	4.9	12.8	9,275	726
St. Clement	1,044	1.6	4.2	7,205	1,707
St. Helier	2,125	3.3	8.6	27,549	3,203
St. John	2,154	3.4	8.7	2,420	278
St. Lawrence	2,337	3.7	9.5	4,415	467
St. Martin	2,455	3.8	9.9	3,271	329
St. Mary	1,602	2.5	6.5	1,442	223
St. Ouen	3,707	5.8	15.0	3,461	231
St. Peter	2,875	4.5	11.6	4,209	362
St. Saviour	2,296	3.6	9.3	12,795	1,377
Trinity	3,030	4.7	12.3	2,594	212
All island	28,717	44.9	116.2	82,809	713

* persons per square kilometre

Population

The 1989 year-end resident population was estimated departmentally to be 82,750 — 40,089 males and 42,661 females.

In arriving at this estimate the 1989 census figures were used as a basis and to these were added births and subtracted deaths that have occurred in Jersey from 13th March 1989 to 31st December 1989.

TABLE I — 2

1989 estimated year-end resident population

	Males	Females	Totals
Resident population: midnight 12th March 1989 census	39,954	42,582	82,536
Births: 13th March 1989 to 31st December 1989 .	442	427	869
	40,396	43,009	83,405
Deaths: 13th March 1989 to 31st December 1989 .	307	348	655
Estimated year-end resident population	40,089	42,661	82,750

TABLE I — 3
Resident population — Census 1989

Age Group	Male	Female	Total
0 – 4	2,321	2,133	4,454
5 – 9	2,067	2,071	4,138
10 – 14	2,012	2,014	4,026
15 – 19	2,576	2,538	5,114
20 – 24	3,991	4,162	8,153
25 – 29	3,856	3,977	7,833
30 – 34	3,362	3,502	6,864
35 – 39	3,129	3,137	6,266
40 – 44	3,147	3,086	6,233
45 – 49	2,498	2,425	4,923
50 – 54	2,449	2,340	4,789
55 – 59	2,086	2,081	4,167
60 – 64	1,861	1,914	3,775
65 – 69	1,511	1,958	3,469
70 – 74	1,157	1,621	2,778
75 – 79	1,045	1,517	2,562
80 – 84	589	1,178	1,767
85 – 89	231	626	857
90 – 94	57	238	295
95 – 99	8	55	63
100 and over	1	9	10
Total	39,954	42,582	82,536

	Males	Females	Total
15.29% of the resident population was under 15 years of age	6,400	6,218	12,618
25.56% of the resident population were between 15 and 29 years of age	10,423	10,677	21,100
23.46% of the resident population were between 30 and 44 years of age	9,638	9,725	19,363
21.39% of the resident population were between 45 and 64 years of age	8,894	8,760	17,654
14.30% of the resident population were aged 65 and over	4,599	7,202	11,801

FIGURE I – 1 **POPULATION 1821 – 1989**

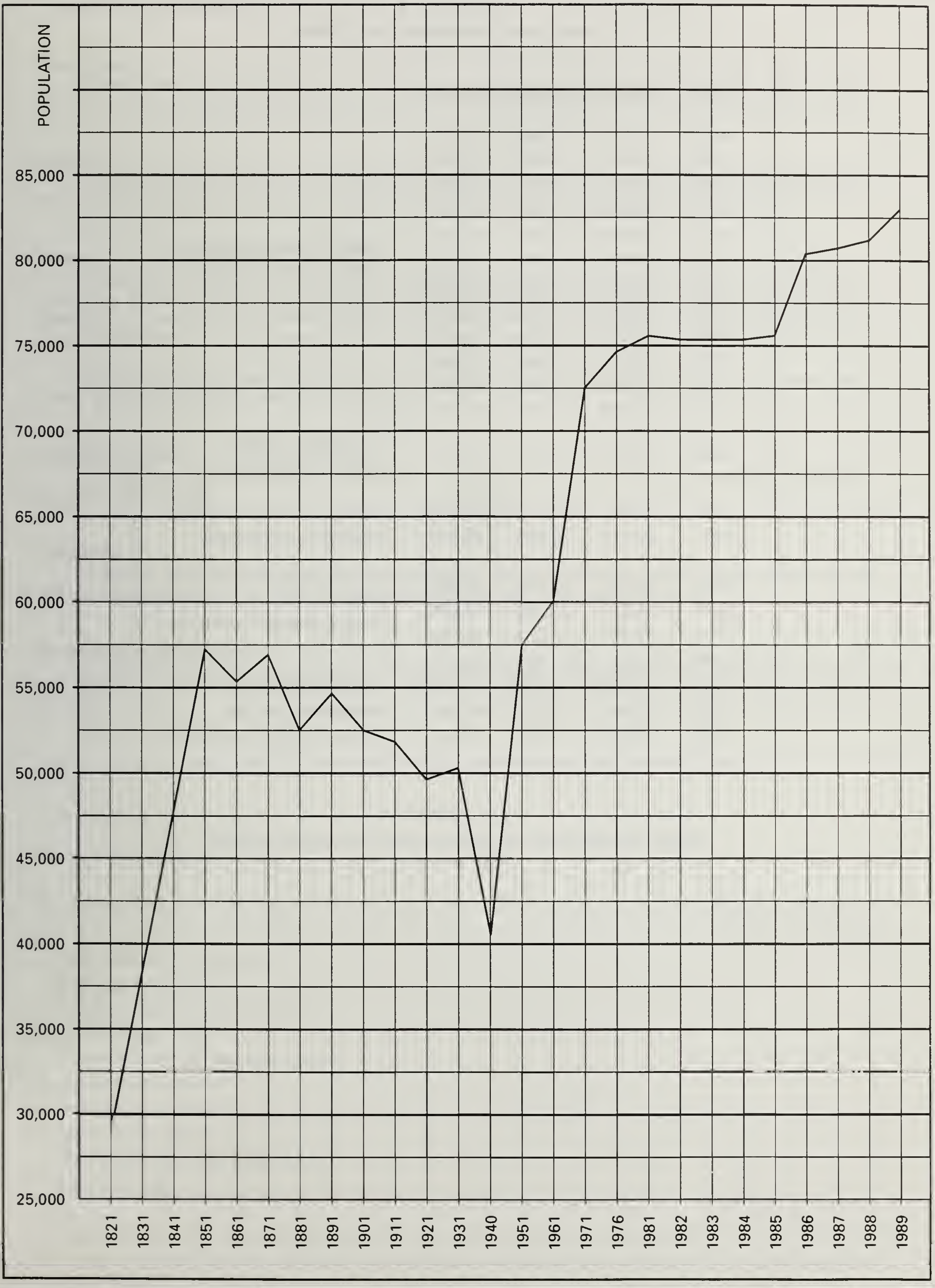


TABLE I — 4

Jersey total population 1821—1989

Year	Males	Females	Persons	
1821	13,056	15,544	28,600	Census – total population (resident and foreign)
1831	17,006	19,576	36,582	
1841	21,602	25,942	47,544	
1851	26,238	30,782	57,020	
1861	24,843	30,770	55,613	
1871	24,875	31,752	56,627	
1881	23,485	28,960	52,445	
1891	24,965	29,553	54,518	
1901	23,940	28,636	52,576	
1911	24,014	27,884	51,898	
1921	22,438	27,263	49,701	
1931	23,424	27,038	50,462	
1940	18,766	22,335	41,101	Occupation Census — resident population
1951	27,291	30,019	57,310	Census — total population (resident and foreign)
1961	30,715	32,835	63,550	
1971	36,167	37,136	72,303	Census (resident population)
1976	36,010	38,460	74,470	
1981	36,496	39,554	76,050	
1986	38,751	41,461	80,212	
1987	38,868	41,498	80,366	Estimated mid-year resident population
1988	39,000	41,602	80,602	
1989	39,954	42,582	82,536	Census (resident population

Population characteristics

Marriages

There were 651 marriages during 1989, 44 less than in 1988. The marriage rate (persons married per 1,000 estimated population) was 15.73 and the average rate for the last three years 16.40.

Divorces

There were 186 divorces during 1989, 52 less than in 1988. The divorce rate, (persons divorced per 1,000 estimated population) was 4.50 and the average rate for the last three years 5.17.

Births

There were 1,074 live babies born in 1989 (547 males and 527 females) compared with 1,071 in 1988. The crude birth rate was 13.0 per 1,000 estimated population showing the same rate as the previous year and giving an average figure of 13.0 over the last three years. 1,073 babies were born in the Maternity Unit of the General Hospital and one was born at home.

Male births again exceeded female births, giving an average percentage of 5.0 more males being born than females, over the last 5 years.

Illegitimate births

170 (15.8%) babies were born outside marriage, indicating a very slight reduction on last years figure of 172 (16.1%).

Stillbirths

2 babies, both females were registered stillborn, giving a stillbirth rate of 1.9 per 1,000 (live and still), compared with 3.7 in 1988. The average over the last three years being 3.5

Congenital malformations

In 1989 10 babies (all live born) were reported as having congenital malformations, a rate of 9.3 per 1,000 total births, compared with 13.0 in 1988, and giving an average rate over the last three years of 13.7.

TABLE I — 5

Notified congential malformation, live and stillborn babies during 1989

	Males	Females
Cleft lip and cleft palate	1	—
Pulmonary stenosis	1	—
Transposition of great vessel	1	—
Oesophageal fistula	1	—
Tracheal atresia (neo-natal death)	1	—
Hypochondroplasia	—	1
Oesophageal atresia	1	—
Atrial septal defect	1	—
Hydrocephalus (neo-natal death)	1	—
Biliary atresia	1	—
Totals	9	1

TABLE I — 6

Live births, and live birth rates illegitimate births 1974 — 1989

Year	Total live births	Crude birth rate per 1,000 estimated population	Illegitimate births	Illegitimate iive births per cent of total live births
1974	818	11.4	66	8.1
1979	884	11.9	93	10.5
1984	931	12.3	106	11.4
1989	1,074	13.0	170	15.8

TABLE I — 7

Live births by month of birth 1989

	Males	Females	Totals
January	49	28	77
February	43	39	82
March	35	62	97
April	42	46	88
May	58	49	107
June	51	43	94
July	39	55	94
August	41	41	82
September	58	48	106
October	51	43	94
November	41	28	69
December	39	45	84
Monthly average	45.6	43.9	89.5
Totals	547	527	1,074

TABLE I — 8

Live births by sex, legitimacy and parity (birth order) 1989

Position in family	MALES				FEMALES				Totals	% of totals
	Full-term		Premature		Full-term		Premature			
	Leg.	Illeg.	Leg.	Illeg.	Leg.	Illeg.	Leg.	Illeg.		
1st	173	57	16	10	172	41	11	4	484	45.1
2nd	167	15	12	6	164	22	18	—	404	37.6
3rd	55	5	2	—	60	2	5	—	129	12.0
4th	14	1	1	—	18	2	2	—	38	3.5
5th and over	9	4	—	—	5	1	—	—	19	1.8
Totals	418	82	31	16	419	68	36	4	1,074	100.0%

TABLE I — 9

Live births by sex, legitimacy and age of mother 1989

Maternal age group (years)	Males		Females		Totals	% of totals
	Leg.	Illeg.	Leg.	Illeg.		
15 – 19	6	12	3	10	31	2.9
20 – 24	55	38	63	26	181	16.8
25 – 29	162	20	167	20	369	34.4
30 – 34	163	20	163	10	356	33.1
35 – 39	57	6	48	5	116	10.8
40 – 44	6	2	11	1	21	2.0
Totals	549	98	455	72	1,074	100.0%

TABLE I — 10

Live births by sex, parity (birth order) and age of mother 1989

Age groups (years)	Position in family										Totals	% of totals
	Males					Females						
	1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th		
15 – 19	15	3	—	—	—	10	2	1	—	—	31	2.9
20 – 24	67	22	2	—	1	52	31	3	3	—	181	16.8
25 – 29	95	70	9	6	2	97	68	20	1	1	369	34.4
30 – 34	67	66	35	7	8	55	82	26	9	1	356	33.1
35 – 39	10	34	15	3	1	14	17	13	7	2	116	10.8
40 – 44+	2	5	1	—	1	—	4	4	2	2	21	2.0
Totals	256	200	62	16	13	228	204	67	22	6	1,074	100.0%

TABLE I — 11

Notification of low weight live and stillbirths by weight and mortality 1989

Weight groups	Low weight live births	Deaths within 24 hours of birth	Deaths within 28 days of birth	Deaths within 28 days per 1,000 live low weight births	Low weight stillbirths	Low weight stillbirths per 1,000 live and still low weight births
— 1,000g (2lbs 3oz)	2	1	1	500.	—	—
— 1,500g (3lbs 4oz)	8	1	1	125.	1	125.0
— 2,000g (4lbs 6oz)	15	—	—	—	—	—
— 2,250g (4lbs 15 oz)	13	—	—	—	—	—
— 2,500g (5lbs 8oz)	32	—	—	—	1	31.2
All babies of 2,500g (5lbs 8oz) or less	70	2	2	28.6	2	28.6

TABLE I — 12

Stillbirths and stillbirth rates 1974—1989

Year	No. of stillbirths	Rate per 1,000 live and stillbirths
1974	15	18.0
1979	11	12.3
1984	5	5.3
1988	2	1.9

TABLE I — 13

Total births (live and still) by sex, legitimacy and mother's length of residence in Jersey 1989

Maternal length of residence in Jersey	Live births				Stillbirths				Totals	% of totals
	Males		Females		Males		Females			
	Leg.	Illeg.	Leg.	Illeg.	Leg.	Illeg.	Leg.	Illeg.		
Under 9 months	12	7	14	3	—	—	—	—	36	3.4
9 months – under 1 year	1	—	2	2	—	—	—	—	5	0.5
1 year – under 2 years	14	11	9	5	—	—	—	—	39	3.6
2 years – under 3 years	10	3	25	—	—	—	—	—	38	3.5
3 years – under 4 years	15	—	20	2	—	—	—	—	37	3.5
4 years – under 5 years	26	2	14	3	—	—	—	—	45	4.2
5 years and over	176	23	177	19	—	—	2	—	397	36.9
Natives	195	51	194	38	—	—	—	—	478	44.4
Visitors	—	1	—	—	—	—	—	—	1	0.0
Totals	449	98	455	72	—	—	2	—	1,076	100.0%

13 sets of twins — 4 male sets, 6 female sets and 3 mixed sets — were born during the year. Two sets were illegitimate (1 male set and 1 mixed set), only 4 sets were full-term and 17 of the 26 babies weighed under 2,500g at birth.

All the above figures include babies born in Jersey (1 of which was born prematurely to a visitor) but infants born to Jersey residents out of the Island are not included.

Low birth weight babies

Notifications in 1989 of babies born to Jersey residents weighing 2,500g or less at birth showed low birth weight live births as representing 6.5% of all live births, and low birth weight live and stillbirths represented 6.7% of all live and stillbirths.

Table I - 11 analyses low birth weight babies by birth weight and mortality. 35.7% of all low birth weight babies were 2,000g or less, and 2.9% 1,000g or less.

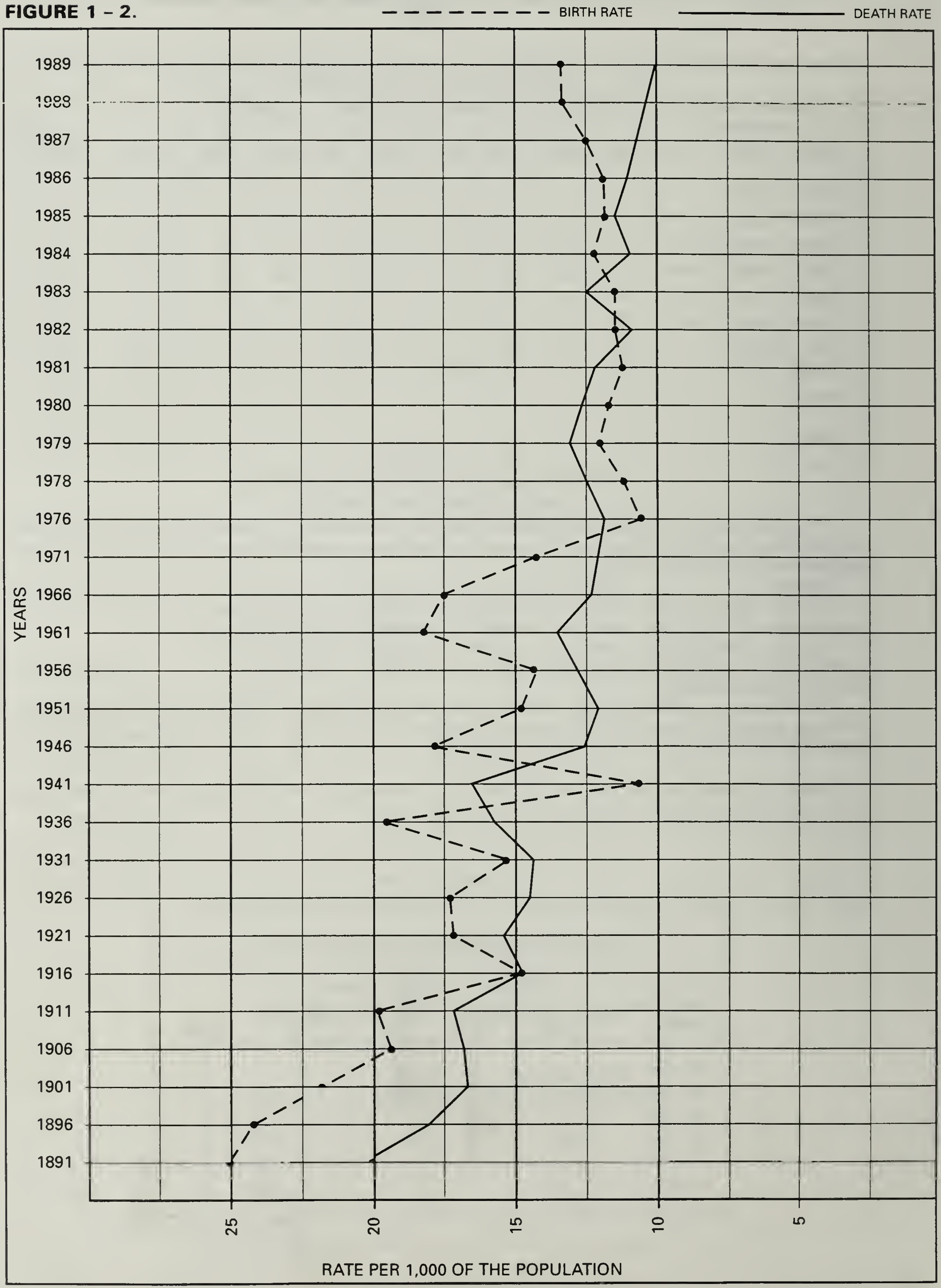
TABLE I — 14

Stillbirths by sex, legitimacy, sex and age of mother

Age groups (years)	Males		Females		Totals
	Leg.	Illeg.	Leg.	Illeg.	
20 – 24	—	—	—	—	—
25 – 29	—	—	—	—	—
30 – 34	—	—	1	—	1
35 – 39	—	—	1	—	1
Totals	—	—	2	—	2

BIRTH AND DEATH RATES 1891 – 1989
PER 1,000 OF THE POPULATION

FIGURE 1 – 2.



Deaths

The deaths of 827 Jersey residents were registered in Jersey during 1989 — 398 males and 429 females. The crude death rate was 10.00 per 1,000 estimated population compared with 10.40 for 1988 and an average for the last three years of 10.30. The percentage of deaths aged 64 and over as a percentage of total deaths was 81.2 for males and 90.2 for females; a similar percentage of those aged 75 and over was 51.0 for males and 69.5 for females.

The average age at death remained the same as last year — 71 years (males) and 78 (females).

TABLE I — 15

Deaths and death rates 1967—1989

Year	Number of deaths			Crude death rate per 1,000 estimated population	Standardised death rate
	Males	Females	Totals		
1967	426	352	778	12.3	10.9
1972	485	422	907	12.6	11.2
1977	453	463	916	12.3	11.6
1982	407	441	848	11.2	10.9
1987	427	418	845	10.5	10.2
1988	415	395	810	10.4	9.7
1989	398	429	827	10.0	9.7

The aforementioned mortality figures do not include deaths of visitors to the Island nor deaths of Jersey residents who died out of the Island.

From the information given on the form which accompanies the medical certificate of the cause of death we can recognise visitors to Jersey, but the number of Jersey residents who died out of the Island is less exact. We receive medical certification of the cause of death when the body of a deceased person is returned to Jersey for "burial" or "cremation", but can rely only on newspaper reports or information realised from medical practitioners concerning those who are buried or cremated away from the Island.

Figures for 1989 were:—

Visitors dying in Jersey	69
Jersey residents dying away from the Island	27

Of the 69 (36 males and 33 females) visitors who died in Jersey during 1989, 46 (24 males and 22 females) died from ischaemic heart disease, a cause representing 66.67% of all deaths amongst visitors. In fact, ischaemic heart disease accounted for 67% of male deaths and 67% of female deaths amongst visitors.

TABLE I — 16

Percentage of total deaths occurring at certain ages and average age at death
1965 — 1989

Year	Under 40 years			40 — 49 years			50 — 59 years			60 — 64 years			65 years and upwards			75 years and upwards			Average age at death (year)		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1985	3.8	2.6	3.2	3.4	2.8	3.1	10.1	4.9	7.5	8.3	5.8	7.0	74.3	84.0	79.1	45.5	63.1	54.3	70	76	73
1986	4.8	3.6	4.2	4.6	3.0	3.8	10.6	4.6	7.6	9.9	4.6	7.2	70.1	84.3	77.2	46.0	64.0	55.0	69	75	72
1987	3.7	3.1	3.4	3.0	3.3	3.1	9.1	6.7	7.9	10.8	4.3	7.5	73.3	82.5	77.9	46.8	62.0	54.4	70	75	72
1988	4.5	2.5	3.5	3.3	1.0	2.2	7.2	5.8	6.5	10.8	4.5	7.7	73.9	86.0	79.8	48.1	69.6	58.6	71	78	74
1989	4.8	2.1	3.4	5.5	2.1	3.8	8.5	5.6	7.0	6.3	3.3	4.7	74.9	86.9	81.1	51.0	69.5	60.6	71	78	74
Average 1965—1969	7.7	5.4	6.6	4.3	3.2	3.8	13.7	7.7	10.8	12.4	6.5	9.5	61.8	77.3	69.2	34.9	55.9	45.0	66	72	69
Average 1970—1974	6.1	2.7	4.5	4.2	3.1	3.6	11.4	6.8	9.0	12.1	6.4	9.4	65.7	81.1	73.2	35.3	60.0	47.0	67	75	71
Average 1975—1979	5.5	3.2	4.4	4.2	2.3	3.3	11.9	7.6	9.8	9.4	6.2	7.8	69.2	80.6	74.7	38.9	58.2	48.4	68	74	71
Average 1980—1984	5.0	2.3	3.7	3.9	2.3	3.1	11.0	7.0	9.0	9.9	5.9	7.9	70.3	82.5	76.4	40.3	62.8	51.5	69	76	73
Average 1985—1989	4.3	2.7	3.5	3.9	2.4	3.2	9.1	5.5	7.3	9.2	4.5	6.8	73.3	84.7	79.0	47.4	65.6	56.5	70	76	73

TABLE I — 17

Deaths registered in the various parishes of the Island during the year 1989 by month of registration

Parish	Jan.		Feb.		March		April		May		June		July		August		Sept.		Oct.		Nov.		Dec.		Totals	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
St. Helier	27	25	25	24	33	19	18	19	24	23	15	22	21	17	20	21	19	20	27	26	19	16	19	32	267	264
St. Saviour	4	9	2	4	2	1	3	2	3	4	2	7	—	5	3	1	—	3	2	6	3	3	5	9	29	54
St. Clement	1	3	—	—	—	—	—	1	—	2	—	3	—	1	—	1	—	1	—	1	1	2	1	1	3	16
Grouville	7	3	5	7	2	5	2	3	3	6	3	3	3	4	4	5	5	3	7	3	2	4	1	6	44	52
St. Martin	3	1	—	—	1	—	—	2	—	—	1	—	—	—	—	—	2	1	1	—	2	—	1	1	11	5
Trinity	—	1	—	—	1	—	1	—	—	—	—	—	—	—	1	—	—	1	2	1	1	—	1	2	7	5
St. John	—	—	—	—	—	—	1	—	—	—	—	1	1	—	1	—	—	—	1	1	1	—	1	—	6	2
St. Mary	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	2	—	—	1	—	1	—	3	2
St. Ouen	—	1	1	—	—	—	—	1	1	—	—	—	1	1	—	—	1	—	1	—	—	—	—	1	5	4
St. Peter	1	—	—	2	1	1	1	—	1	2	—	1	—	3	2	—	—	—	—	3	—	1	1	2	7	15
St. Brelade	3	3	4	3	—	1	—	2	4	3	4	5	4	6	7	2	3	1	4	4	2	4	1	2	36	36
St. Lawrence	2	—	1	1	1	—	2	2	4	—	2	1	2	—	—	—	—	1	1	2	—	—	1	—	16	7
Totals	**48**	**46**	**38**	**41**	**41**	**27**	**28**	**32**	**40**	**40**	**27**	**43**	**32**	**37**	**39**	**30**	**30**	**33**	**46**	**47**	**32**	**30**	**33**	**56**	**434**	**462**

Total: 896

TABLE I — 18

Visitors who died in Jersey classified by cause of death and sex 1989

	Males	Females	Totals
Malignant neoplasm of stomach	—	1	1
Malignant neoplasm of intestine, except rectum	1	—	1
Malignant neoplasm of trachea, bronchus and lung	1	1	2
Malignant neoplasm of other and unspecified sites	—	1	1
Hypertensive disease	—	1	1
Ischaemic heart disease	24	22	46
Other forms of heart disease	—	2	2
Cerebrovascular disease	—	1	1
Diseases of arteries, arterioles and capillaries	4	2	6
Venous thrombosis and embolism	2	—	2
Other pneumonia	1	1	2
Cirrhosis of liver	—	1	1
Accidental poisoning	2	—	2
Accidental drowning and submersion	1	—	1
Totals	36	33	69

The figures shown in the table above have not been included in any other statistical table or report for 1989.

In the past deaths registered in Jersey of visitors to the Island were included in all relevant statistics.

TABLE I — 19

Causes of death of infants within first year of life
1989

	Age at death							
	Under 7 days		7–28 days		1–12 months		Totals	
Cause	M	F	M	F	M	F	M	F
Viral Pneumonia	—	—	—	—	—	1	—	1
Intrapartum asphyxia, Tracheal atresia, Oesophageal stenosis and fistula	1	—	—	—	—	—	1	—
Hydrocephalus	1	—	—	—	—	—	1	—
Respiratory insufficiency, extreme prematurity	1	—	—	—	—	—	1	—
Totals	3	—	—	—	—	1	3	1

TABLE I — 20

Maternal and infant deaths and mortality rates
1958—1989

	Maternal		Peri-natal		Early neo-natal		Neo-natal		Total infant	
Year	Deaths	Rate per 1,000 total live and stillbirths	Deaths	Rate per 1,000 total live and stillbirths	Deaths	Rate per 1,000 total live births	Deaths	Rate per 1,000 total live births	Deaths	Rate per 1,000 total live births
1958	2	2.1	32	33.2	10	10.6	12	12.7	17	18.0
1963	—	—	30	23.1	12	9.4	14	10.9	22	17.2
1968	—	—	23	21.1	10	9.3	13	12.0	18	16.7
1973	—	—	17	19.8	5	5.9	5	5.9	6	7.1
1978	—	—	23	26.7	13	15.3	13	15.3	18	21.1
1983	—	—	3	3.4	1	1.1	1	1.1	7	7.9
1985	—	—	13	14.3	6	6.6	6	6.6	9	9.9
1986	—	—	6	5.3	4	4.2	4	4.2	5	5.3
1987	—	—	11	10.8	6	5.9	8	7.9	14	13.9
1988	—	—	11	10.2	7	6.5	8	7.5	11	10.3
1989	—	—	5	4.6	3	2.8	3	2.8	4	3.7

Infant mortality

There were 4 infant deaths (children aged less than one year) during 1989, 3 males and 1 female, providing an infant mortality rate of 3.7 per 1,000 live births, as against 10.3 for 1988 and 13.9 for 1987. This shows an average of 9.3 per 1,000 live births over 3 years. None of the babies born in Jersey died in mainland hospitals.

Neo-natal mortality

There were 3 neo-natal deaths (children aged 4 weeks and under) during 1989 — 75% of all deaths in the first year — giving a neo-natal mortality rate of 2.8 per 1,000 live births compared with 7.5 in 1988 and 7.9 in 1987.

Early neo-natal

The 3 babies mentioned in the paragraph above were all early neo-natal (children aged under one week) giving a mortality rate of 2.8 per 1,000 live births compared with 6.5 in 1988 and 5.9 in 1987.

Peri-natal mortality

Peri-natal mortality combines stillbirth and early neo-natal deaths and provides the best indicator of pregnancy health, and childbirth hazards for the infant.

There were 5 peri-natal deaths in 1989 giving a peri-natal mortality rate of 4.6 per 1,000 live and stillbirths, compared with 10.2 in 1988 and 10.8 in 1987.

Maternal mortality

There have been no maternal deaths in Jersey since 1971 — an excellent record perhaps due mainly to the rarity of home confinements. Nearly all babies in Jersey are born in the Maternity Unit of the General Hospital, where support services of a high standard are available to deal with emergencies.

TABLE I — 21

Deaths (exclusive of foetal deaths), cross-classified by sex and cause registered 1987 — 1989

	1987			1988			1989		
	M	F	T	M	F	T	M	F	T
GROUP I — Infective and parasitic diseases	1	1	2	5	2	7	1	4	5
GROUP II — Neoplasms	123	111	234	107	100	207	111	112	223
GROUP III — Endocrine, nutritional and metabolic diseases	—	3	3	4	4	8	2	10	12
GROUP IV — Diseases of the blood and blood forming organs	1	1	2	—	—	—	—	—	—
GROUP V — Mental disorders	—	1	1	3	1	4	—	—	—
GROUP VI — Diseases of the nervous system and sense organs	4	7	11	5	3	8	3	4	7
GROUP VII — Diseases of the circulatory system	203	173	376	184	180	364	177	175	352
GROUP VIII — Diseases of the respiratory system	58	73	131	64	63	127	58	80	138
GROUP IX — Diseases of the digestive system	11	9	20	11	9	20	11	11	22
GROUP X — Diseases of the genito-urinary system	4	7	11	9	3	12	7	3	10
GROUP XI — Complications of pregnancy, childbirth and the puerperium	—	—	—	—	—	—	—	—	—
GROUP XII — Diseases of the skin and subcutaneous tissue	—	—	—	—	—	—	—	—	—
GROUP XIII — Diseases of the musculoskeletal system and connective tissue	1	4	5	—	6	6	1	2	3
GROUP XIV — Congenital anomalies	2	1	3	3	—	3	2	1	3
GROUP XV — Certain causes of perinatal mortality	2	1	3	2	3	5	1	—	1
GROUP XVI — Symptoms and ill-defined conditions	6	15	21	1	10	11	6	15	21
GROUP XVII — Accidents, poisonings and violence	11	11	22	17	11	28	18	12	30
Totals	**427**	**418**	**845**	**415**	**395**	**810**	**398**	**429**	**827**

FIGURE 1 - 3

JERSEY, 1989

DEATHS FROM PRINCIPAL CAUSES.
RATE PER 1,000 POPULATION
PERCENTAGE OF TOTAL DEATHS

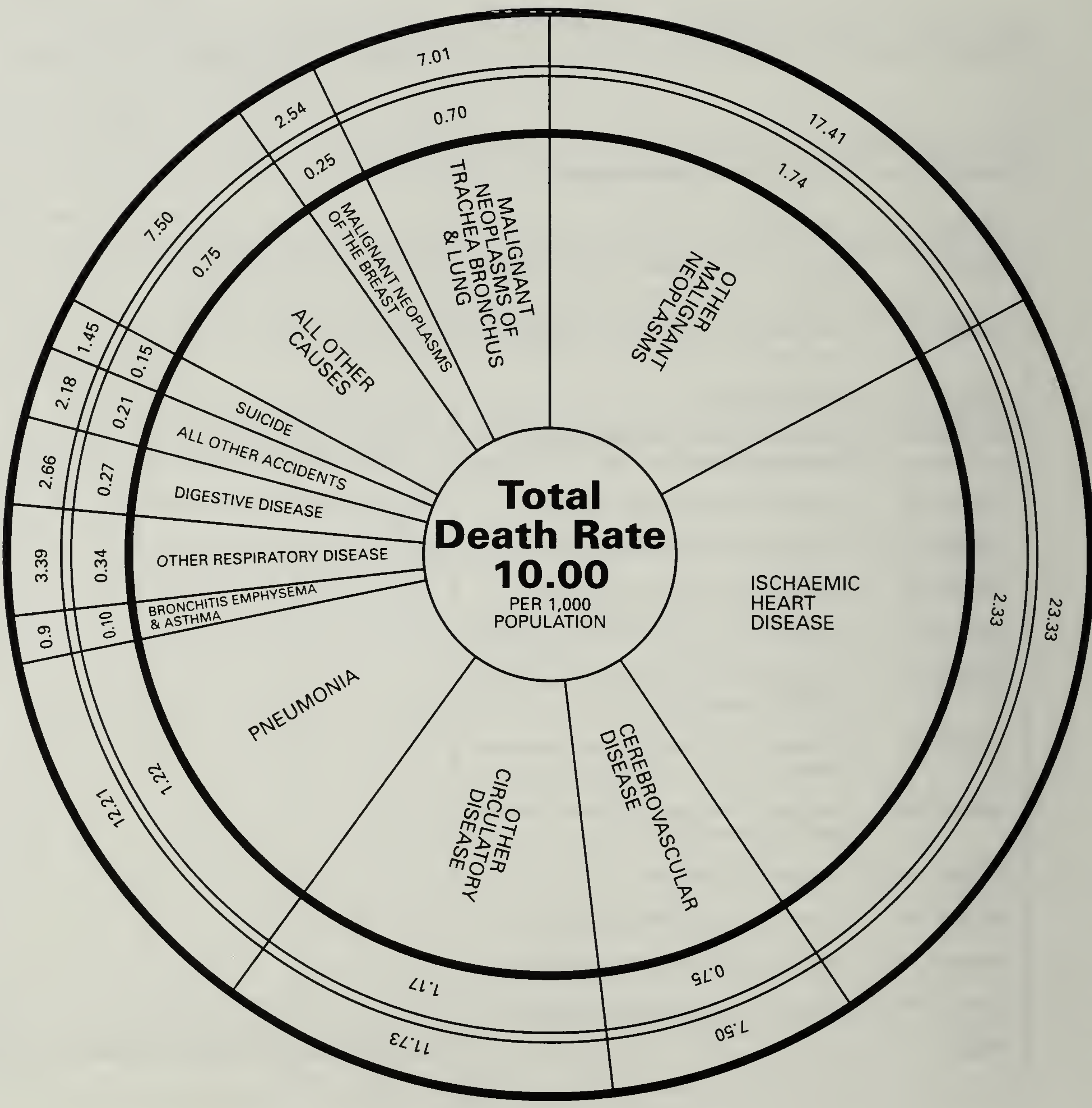


TABLE I — 22

Deaths (exclusive of foetal deaths) cross-classified by cause, sex and age registered during 1989 — MALE

	MALE																	
	All Ages	Under 1 year	1–4 years	5–9 years	10–14 years	15–19 years	20–24 years	25–29 years	30–34 years	35–39 years	40–44 years	45–49 years	50–54 years	55–59 years	60–64 years	65–69 years	70–74 years	75 and over
GROUP I — INFECTIVE AND PARASITIC DISEASES																		
Other bacterial diseases	1																	1
Total	1																	1
GROUP II — NEOPLASMS																		
Malignant neoplasm of buccal cavity and pharynx	2										1							1
Malignant neoplasm of oesophagus	3														1	1	1	
Malignant neoplasm of stomach	5																2	3
Malignant neoplasm of intestine, except rectum	6													1		1	3	1
Malignant neoplasm of rectum and rectosigmoid junction	3										1	1						1
Malignant neoplasm of larynx	1														1			
Malignant neoplasm of trachea, bronchus and lung	37										1	3	1	4	2	7	4	15
Malignant neoplasm of bone	2													1		1		
Malignant neoplasm of prostate	21														1	3	4	13
Malignant neoplasm of other and unspecified sites	24									2	1		1	2	2	2	4	10
Leukaemia	1																1	
Other neoplasms of lymphatic & haemotopoietic tissue	6												2				1	3
Total	111									2	4	4	4	8	7	15	20	47
GROUP III — ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES																		
Diabetes Mellitus	2																	2
Total	2																	2
GROUP VI — DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS																		
Other diseases of the nervous system and sense organs	3																2	1
Total	3																2	1
GROUP VII — DISEASES OF THE CIRCULATORY SYSTEM																		
Hypertensive disease	6									1					1	1	2	1
Ischaemic heart disease	111							1				3	7	6	6	19	14	55
Other forms of heart disease	13											1		1		1	1	9
Cerebrovascular disease	22										1				1	2	3	15
Diseases of arteries, arterioles and capillaries	19										1	1			2	4		11
Venous thrombosis and embolism	6													1			1	4
Total	177							1		1	2	5	7	8	10	27	21	95
GROUP VIII — DISEASES OF THE RESPIRATORY SYSTEM																		
Viral pneumonia	1																	1
Other pneumonia	41		1										3			3	1	33
Bronchitis, emphysema and asthma	1														1			
Other diseases of respiratory system	15														3	3	1	8
Total	58		1										3		4	6	2	42

TABLE I — 22

Deaths (exclusive of foetal deaths) cross-classified by cause, sex and age registered during 1989 — MALE

	MALE																	
	All Ages	Under 1 year	1–4 years	5–9 years	10–14 years	15–19 years	20–24 years	25–29 years	30–34 years	35–39 years	40–44 years	45–49 years	50–54 years	55–59 years	60–64 years	65–69 years	70–74 years	75 and over
GROUP IX — DISEASES OF THE DIGESTIVE SYSTEM																		
Peptic ulcer	1																	1
Intestinal obstruction and hernia	1															1		
Cirrhosis of liver	7											1	1	1	2	1		1
Other diseases of digestive system	2						1											1
Total	11						1					1	1	1	2	2		3
GROUP X — DISEASES OF GENITO-URINARY SYSTEM																		
Other nephritis and nephrosis	7									1								6
Total	7									1								6
GROUP XIII — DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE																		
Ankylosis and acquired musculoskeletal deformities	1														1			
Total	1														1			
GROUP XIV — CONGENITAL ANOMALIES																		
All other congenital anomalies	2	2																
Total	2	2																
GROUP XV — CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY																		
Other causes of perinatal morbidity & mortality	1	1																
Total	1	1																
GROUP XVI — SYMPTOMS AND ILL-DEFINED CONDITIONS																		
Senility without mention of psychosis	4																	4
Symptoms and other ill-defined conditions	2																	2
Total	6																	6
GROUP XVII — ACCIDENTS, POISONINGS AND VIOLENCE																		
Motor vehicle accidents	2					1				1								
Accidental poisoning	3								1		1	1						
Accidental falls	3					1			2									
Accidental drowning and submersion	1													1				
All other accidents	1										1							
Suicide and self inflicted injury	8					1		1	1		1	2		1	1			
Total	18					3		1	4	1	3	3		2	1			
ALL CAUSES	398	3	1	—	—	3	1	2	4	5	8	14	15	19	25	50	45	203

TABLE I — 23

Deaths (exclusive of foetal deaths) cross-classified by cause, sex and age registered during 1989 — FEMALE

	FEMALE																	
	All Ages	Under 1 year	1—4 years	5—9 years	10—14 years	15—19 years	20—24 years	25—29 years	30—34 years	35—39 years	40—44 years	45—49 years	50—54 years	55—59 years	60—64 years	65—69 years	70—74 years	75 and over
GROUP I — INFECTIVE AND PARASITIC DISEASES																		
Other bacterial diseases	4															1	1	2
Total	**4**															**1**	**1**	**2**
GROUP II — NEOPLASMS																		
Malignant neoplasm of buccal cavity and pharynx	2													1			1	
Malignant neoplasm of oesophagus	4														1		1	2
Malignant neoplasm of stomach	5																1	4
Malignant neoplasm of intestine, except rectum	9														1		2	6
Malignant neoplasm of rectum and rectosigmoid junction	6														1		1	4
Malignant neoplasm of larynx	1																1	
Malignant neoplasm of trachea, bronchus and lung	21										3		2		2	6	1	7
Malignant neoplasm of breast	21								1				3	4	2	5	1	5
Malignant neoplasm of cervix uteri	2									1								1
Other malignant neoplasm of uterus	9											1		1			2	5
Malignant neoplasm of other and unspecified sites	26											1	1	2	3	4	3	12
Leukaemia	2														1		1	
Other neoplasms of lymphatic & haemotopoietic tissue	4						1											3
Total	**112**						**1**		**1**	**1**	**3**	**2**	**6**	**8**	**11**	**15**	**15**	**49**
GROUP III — ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES																		
Diabetes Mellitus	9																1	8
Other endocrine and metabolic diseases	1							1										
Total	**10**							**1**									**1**	**8**
GROUP VI — DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS																		
Multiple sclerosis	1										1							
Other diseases of the nervous system and sense organs	3															1		2
Total	**4**										**1**					**1**		**2**
GROUP VII — DISEASES OF THE CIRCULATORY SYSTEM																		
Chronic rheumatic heart disease	3													1			1	1
Hypertensive disease	7															1	1	5
Ischaemic heart disease	82												1			8	12	61
Other forms of heart disease	13														1		1	11
Cerebrovascular disease	40								1							2	1	36
Diseases of arteries, arterioles and capillaries	14															1	1	12
Venous thrombosis and embolism	12																	12
Other diseases of circulatory system	4																	4
Total	**175**								**1**				**1**	**1**	**1**	**12**	**17**	**142**

TABLE I — 23

Deaths (exclusive of foetal deaths) cross-classified by cause, sex and age registered during 1989 — FEMALE

	FEMALE																	
	All Ages	Under 1 year	1–4 years	5–9 years	10–14 years	15–19 years	20–24 years	25–29 years	30–34 years	35–39 years	40–44 years	45–49 years	50–54 years	55–59 years	60–64 years	65–69 years	70–74 years	75 and over
GROUP VIII — DISEASES OF THE RESPIRATORY SYSTEM																		
Influenza	2																	2
Viral pneumonia	2	1																1
Other pneumonia	60													1		1	4	54
Bronchitis, emphysema and asthma	8											1						7
Other diseases of respiratory system	8														1		1	6
Total	**80**	**1**										**1**		**1**	**1**	**1**	**5**	**70**
GROUP IX — DISEASES OF THE DIGESTIVE SYSTEM																		
Peptic ulcer	2																1	1
Intestinal obstruction and hernia	1																	1
Cirrhosis of liver	5										1		2	2				
Cholelithiasis and cholecystitis	2																	2
Other diseases of digestive system	1												1					
Total	**11**										**1**		**3**	**2**			**1**	**4**
GROUP X — DISEASES OF GENITO-URINARY SYSTEM																		
Other nephritis and nephrosis	1																	1
Infections of kidney	1																	1
Other diseases of genito-urinary system	1															1		
Total	**3**															**1**	**2**	
GROUP XIII — DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE																		
Ankylosis and acquired musculoskeletal deformities	1														1			
Other diseases of musculoskeletal and connective tissue	1					1												
Total	**2**					**1**									**1**			
GROUP XIV — CONGENITAL ANOMALIES																		
All other congenital anomalies	1																	1
Total	**1**																	**1**
GROUP XVI — SYMPTOMS AND ILL-DEFINED CONDITIONS																		
Senility without mention of psychosis	13																	13
Symptoms and other ill-defined conditions	2																	2
Total	**15**																	**15**
GROUP XVII — ACCIDENTS, POISONINGS AND VIOLENCE																		
Motor vehicle accidents	3																2	1
Accidental poisoning	2															1		1
Accidental falls	1																	1
Accidental drowning and submersion	1												1					
Suicide and self-inflicted injury	4						1		1			1		1				
Injury undetermined whether accidentally or purposely inflicted	1															1		
Total	**12**						**1**		**1**			**1**	**1**	**1**		**2**	**2**	**3**
ALL CAUSES	**429**	**1**	—	—	—	**1**	**2**	**1**	**3**	**1**	**5**	**4**	**11**	**13**	**14**	**33**	**42**	**298**

TABLE I — 24
Some causes of death with their distribution by sex, rate per 1,000 population and percentage of total deaths
1989

Cause	No. of deaths			Rate per 1,000 population			% of total deaths		
	M	F	T	M	F	T	M	F	T
Neoplasms	**111**	**112**	**223**	**2.77**	**2.63**	**2.69**	**27.89**	**26.11**	**26.96**
Oesophagus	3	4	7	0.08	0.10	0.08	0.75	0.93	0.85
Stomach	5	5	10	0.13	0.12	0.12	1.26	1.16	1.21
Intestine, except rectum	6	9	15	0.15	0.21	0.18	1.51	2.10	1.81
Trachea, bronchus and lung	37	21	58	0.92	0.49	0.70	9.30	4.90	7.01
Breast	—	21	21	—	0.49	0.25	—	4.90	2.54
Prostate	21	—	21	0.52	—	0.25	5.27	—	2.54
All other sites	39	52	91	0.97	1.22	1.10	9.80	12.12	11.00
Circulatory diseases	**177**	**175**	**352**	**4.42**	**4.10**	**4.25**	**44.47**	**40.79**	**42.56**
Ischaemic heart disease	111	82	193	2.77	1.92	2.33	27.89	19.11	23.33
Cerebrovascular disease	22	40	62	0.55	0.94	0.75	5.52	9.32	7.50
All other circulatory diseases	44	53	97	1.10	1.24	1.17	11.06	12.35	11.73
Respiratory diseases	**58**	**80**	**138**	**1.45**	**1.88**	**1.66**	**14.57**	**18.65**	**16.69**
Pneumonia, except viral	41	60	101	1.02	1.41	1.22	10.30	13.99	12.21
Bronchitis, emphysema and asthma	1	8	9	0.03	0.19	0.10	0.25	1.86	1.09
All other respiratory diseases	16	12	28	0.40	0.28	0.34	4.02	2.80	3.39
Digestive diseases	**11**	**11**	**22**	**0.27**	**0.26**	**0.27**	**2.76**	**2.56**	**2.66**
Cirrhosis of liver	7	5	12	0.17	0.12	0.15	1.76	1.16	1.45
All other digestive diseases	4	6	10	0.10	0.14	0.12	1.00	1.40	1.21
Accidents, poisonings and violence	**18**	**12**	**30**	**0.45**	**0.28**	**0.36**	**4.52**	**2.80**	**3.63**
Motor vehicle accidents	2	3	5	0.05	0.07	0.06	0.50	0.70	0.61
All other accidents	8	5	13	0.20	0.12	0.15	2.01	1.17	1.57
Suicides	8	4	12	0.20	0.09	0.15	2.01	0.93	1.45
Homicide and injury purposely inflicted by other persons; legal intervention	—	—	—	—	—	—	—	—	—
All other causes including senility	**23**	**39**	**62**	**0.57**	**0.91**	**0.75**	**5.78**	**9.09**	**7.50**
Senility	4	13	17	0.10	0.30	0.20	1.00	3.03	2.50
All other causes	19	26	45	0.47	0.60	0.54	4.77	6.06	5.44

TABLE I — 25

Deaths

It has been calculated from information received that an astonishing total of 3,945 years of life were lost by 281 individuals (an average of 14 years per person) who died as a result of a selected number of causes of death.

The years of life lost up to age 75 were calculated by subtracting the actual age at death from age 75.

The following table shows the breakdown by cause and years lost for males and females:-

	Males		Females			
	Deceased	Number of years lost	Deceased	Number of years lost	Total deceased	Total number of years lost
Malignant neoplasm of buccal cavity & pharynx	1	28	2	20	3	48
Malignant neoplasm of oesophagus	3	26	2	17	5	43
Malignant neoplasm of stomach	2	9	2	14	4	23
Malignant neoplasm of intestine, except rectum	6	57	3	17	9	74
Malignant neoplasm of rectum & rectosigmoid junction	2	57	2	18	4	75
Malignant neoplasm of larynx	1	15	1	2	2	17
Malignant neoplasm of trachea, bronchus & lung	23	326	15	221	38	547
Malignant neoplasm of bone	2	27	—	—	2	27
Malignant neoplasm of breast	—	—	16	239	16	239
Malignant neoplasm of cervix uteri	—	—	1	38	1	38
Other malignant neoplasm of uterus	—	—	4	50	4	50
Malignant neoplasm of prostate	8	53	—	—	8	53
Malignant neoplasm of other & unspecified sites	14	215	14	178	28	393
Leukaemia	1	1	2	17	3	18
Other neoplasms of lymphatic & haemotopoietic tissue	3	49	1	55	4	104
All malignant neoplasms	66	863	65	886	131	1,749
Ischaemic heart disease	74	1,106	35	277	109	1,383
Cerebovascular disease	7	67	5	68	12	135
Diseases of arteries, arterioles & capillaries	11	151	2	12	13	163
Motor vehicle accidents	2	93	2	8	4	101
Suicide & self inflicted injury	8	274	4	140	12	414
Totals	168	2,554	113	1,391	281	3,945

II
Principal causes of death

The relative proportions of the principal cause of death change little from year to year. Circulatory disorders accounted for 42.6% of all deaths in 1989, the main components being ischaemic heart disease (23.3%) and cerebrovascular disease (8%). The second largest cause of death is malignant neoplasms, which account for one in every four deaths (27%), the most frequent sites being the trachea, bronchus and lung (7.1%). The third largest group of causes is respiratory diseases (16.7%), almost entirely made up of pneumonia (12.2%) and bronchitis, emphysema and asthma (1.1%). There is little difference between the fourth and fifth largest groups comprising accidents, poisonings and violence (3.6%) and the digestive diseases (2.7%) of which suicides (1.5%) and cirrhosis of the liver (1.5%) is foremost in each group respectively.

61% of all deaths in 1989 occurred in persons aged 75 years and over.

Cigarette smoking and alcohol consumption remain major contributory factors in many deaths — lung cancer, coronary heart disease and cerebrovascular disease in particular — as well as causing much ill health and efforts must be intensified to discourage people from taking up or continuing smoking and also from excessive alcohol intake.

Smoking

There is increasing concern over the effects of passive smoking — environmental tobacco smoke — on the health of non-smokers. Findings from a wide range of investigations have been published confirming an association between passive smoking and the exacerbation of respiratory and cardiovascular symptoms. Overall findings were consistent with an increase in the risk of lung cancer among non-smokers from exposure to environmental tobacco smoke, possibly between 10% and 30% above those not so exposed.

Cancer (all forms)

223 persons (111 males and 112 females) died from cancer in Jersey in 1989.

The average age at death from cancer was 69 for males and 71 for females. In males cancer of the trachea, bronchus and lung is the lead site for malignant disease causing death, accounting for 33% of such deaths, followed by two sites — stomach and intestine 10% and prostate 19%. For women too, cancer of the trachea, bronchus and lung is now the lead site for malignant disease causing almost a fifth (19%) of all female cancer deaths equalled by cancer of the breast (19%), intestine (8%), the rectum (5%).

TABLE II — 1

Analysis of deaths from all forms of neoplastic disease registered 1989

	Males	Females	Totals
Buccal cavity and pharynx	2	2	4
Oesophagus	3	4	7
Stomach	5	5	10
Intestine, except rectum	6	9	15
Rectum and rectosigmoid junction	3	6	9
Trachea, bronchus and lung	37	21	58
Larynx	1	1	2
Bone	2	—	2
Breast	—	21	21
Cervix uteri	—	2	2
Uterus	—	9	9
Prostate	21	—	21
Other and unspecified sites	24	26	50
Leukaemia	1	2	3
Lymphatic and haemotopoietic tissue	6	4	10
Benign neoplasms and neoplasms of unspecified nature	—	—	—
Totals	111	112	223

The above figures exclude deaths occurring in non-residents and do not include 8 Jersey residents (4 males and 4 females) who died from malignant disease out of the Island. In total 231 Jersey residents (115 males and 116 females) died from cancer in 1989 compared with 207 (107 males and 100 females) in 1988.

Cancer of the lung

37 males and 21 females died from cancer of the lung in Jersey in 1989, providing 26.0% cancer deaths and 6.5% of all deaths. The average age at death was 69 years (males) and 67 years (females).

The above figures are based on deaths of Jersey residents who died in the Island. One Jersey resident, a male aged 66 years died from cancer of the lung on the mainland, therefore, in total 59 Jersey residents (38 males and 21 females) died from lung cancer in 1989, compared with the 1988 total of 50 (26 males and 24 females).

The increasing level of our female cancer death rate is particularly serious and must concern all women who indulge in cigarette smoking as well as those who have lived or worked with smokers over many years. Every effort must be made to discourage young people from taking up the habit and to make them more aware of the risks of exposure to passive smoking.

Cancer of the breast

Cancer of the breast was responsible for 21 female deaths in the Island during 1989 — 18.8% of all female cancer deaths and 4.5% of all female deaths. The average age at death was 65 years.

In addition 3 ladies died from breast cancer on the mainland — making a total of 24 deaths from breast cancer of Jersey residents.

Cancer of the womb

There were two deaths from cancer of the uterine cervix and nine deaths from cancer of other unspecified uterine sites registered in Jersey in 1989. The average age of death from cancer of this site was 72.

Cancer of the intestine, except rectum

Cancer of the intestine caused 15 deaths (6 males and 9 females) in Jersey in 1989. The average age at death was 69 years for males and 81 years for females.

Cancer of the stomach

Cancer of the stomach caused 10 deaths (5 males and 5 females) in Jersey in 1989. The average age at death was 77 years for males and 79 years for females.

Cancer of the prostate

Cancer of the prostate caused the death of 22 Jersey residents in 1989, 21 in Jersey and 1 in the U.K. The average age at death was 75 years.

Circulatory diseases

Circulatory diseases accounted for 42.6% of all deaths, of which 55% were attributed to ischaemic heart disease (coronary thrombosis) and 18% to cerebrovascular disease ("stroke").

A total of 193 persons (111 males and 82 females) died from coronary thrombosis in Jersey during 1989, representing 23% of all deaths. In fact, 28% of male deaths and 19% of female deaths were due to coronary heart disease, which has a marked association with cigarette smoking.

A total of 81 men and 47 women died in the age group 40-64 years, of which 22 males (27%) and 1 female (2%) died from coronary thrombosis.

Sixty-nine visitors died in Jersey during 1989 and 58 of these deaths were attributed to circulatory diseases, 46 deaths (24 males and 22 females) being due to ischaemic heart disease. In comparison, of the 27 Jersey residents who died out of the Island, we know that 11 died from circulatory diseases and of these, 4 (2 males and 2 females) were due to ischaemic heart disease. These figures might be higher as we do not know the cause of death of all Jersey residents who died out of the Island.

TABLE II — 2

Deaths from coronary thrombosis 1965 – 1989

Year	Total deaths			Deaths from coronary disease						Total deaths in age groups 40 – 64			Deaths from coronary disease in age groups 40 – 64					
				No.			%						No.			%		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1985	444	431	875	109	96	205	24.5	22.3	23.4	97	58	155	35	6	41	36.1	10.3	26.5
1986	435	439	874	135	86	221	31.0	19.6	25.3	109	53	162	40	8	48	36.7	15.1	29.6
1987	427	418	845	132	92	224	30.9	22.0	26.4	98	60	158	35	9	44	35.7	15.0	27.8
1988	415	395	810	120	85	205	28.9	21.5	25.3	89	45	134	23	8	31	25.8	17.8	23.1
1989	398	429	827	111	82	193	27.8	19.1	23.4	81	47	128	22	1	23	27.2	2.1	18.0
Average 1965 – 69	419	394	813	97	59	156	23.1	15.0	19.2	127	68	195	41	9	50	32.3	13.2	25.6
Average 1970 – 74	474	429	903	137	75	212	28.9	17.5	23.5	141	70	211	52	10	62	36.9	14.3	29.4
Average 1975 – 79	485	452	937	135	76	211	27.8	16.8	22.5	123	71	194	46	11	57	37.4	15.5	29.4
Average 1980 – 84	450	447	897	133	86	219	29.5	19.2	24.4	112	67	179	43	9	52	38.4	13.4	29.0
Average 1985 – 89	424	422	846	121	88	209	28.6	20.9	24.7	95	53	148	31	6	37	32.3	12.1	25.0

Chronic bronchitis and emphysema

Nine persons (1 male and 8 females) died from chronic bronchitis and emphysema — frequently cigarette smoking related conditions — during the year. The age at death was 64 years for the male and the average age for females was 80 years.

Cirrhosis of liver

Twelve persons (7 males and 5 females) died from cirrhosis of the liver during the year. The average age at death was 60 years for males and for females was 53 years of age.

Cirrhosis of the liver is a condition often associated with an excessive consumption of alcohol, and alcohol dependency is a major problem in the Island. 126 persons (77 males and 49 females) have died from cirrhosis of the liver in Jersey in the last ten years.

Cirrhosis, due to alcohol consumption, is recorded in many persons who die from some other condition and must be accepted as a related factor in such deaths.

Motor vehicle accidents

Five persons (2 males and 3 females) died as a result of motor accidents in 1989 with an average age at death of 57 years, and covering an age range from 18 years to 87 years.

All other accidents

Thirteen persons (10 males and 3 females) died in Jersey following other accidents in 1989. The average age at death for Jersey residents being 35 years with a range of 16 to 77 years.

TABLE II — 3

Types of accident — 1989

Falls	4
Carbon Monoxide poisoning	1
Toxic poisoning	3
Asphyxia	1
Alcohol poisoning	2
Drowning	2

Suicides

Twelve persons (8 males and 4 females) committed suicide in Jersey during the year. The average age at death was 41 for males and 48 for females, with an age range of 18 to 60 years.

TABLE II — 4

Forms of suicide — 1989

Drug poisoning	3
Alcohol and drug poisoning	3
Shooting	2
Hanging	2
Inhaling exhaust fumes	2

Over the past 10 years a total of 107 Jersey residents (71 men and 36 women) have committed suicide.

TABLE II — 5

Suicides by Jersey residents by sex and age groups 1980 – 1989

Age group	Males	Females	Totals
Under 20	7	—	7
20 – 29	8	9	17
30 – 39	12	4	16
40 – 49	13	5	18
50 – 59	11	7	18
60 – 69	10	2	12
70 and over	10	9	19
Totals	71	36	107

III
Cancer Registration

Since 1962 the Public Health Department has been involved in the collection, completion and submission for analysis of confidential information about patients diagnosed as suffering from cancer, normally obtained from hospital consultants or general practitioners.

The information collected is detailed and includes a social history, confirmation of diagnosis, recorded clinical signs and symptoms, any surgical, medical or pathological assessment of the case and the form of treatment given. There is a follow-up when death occurs so that survival periods are recorded.

The value of Jersey's participation in the U.K. scheme has been to:—

a) provide a stimulus to the collection of adequate long-term information about cancer patients, which suggests possible causative factors and permits the efficiency of various treatments to be assessed, and

b) provides an opportunity for the extent and types of cancer in Jersey to be compared with findings from other parts of the U.K.

Cancer is a major cause of death in Jersey and cancer registration is of enormous importance to the ultimate reduction of morbidity and mortality from cancer. The participation in cancer registration locally has been excellent and every co-operation has been received from family doctors and consultants, whether patients were investigated and treated in Jersey or elsewhere.

Using the cases registered from the S.E. and S.W. Thames Regional Health Authority areas in 1987 the risk faced by men and women developing each of the ten most common cancers for their sex in the course of an average lifetime (here taken to be 74 years) has been calculated as follows:—

Men		**Women**	
Lung	1 in 14	Lung	1 in 40
Skin	1 in 25	Skin	1 in 42
Prostate	1 in 44	Breast	1 in 15
Stomach	1 in 65	Stomach	1 in 189
Colon	1 in 63	Colon	1 in 68
Bladder	1 in 51	Ovary	1 in 77
Rectum	1 in 83	Rectum	1 in 128
Pancreas	1 in 127	Pancreas	1 in 185
Oespohagus	1 in 137	Cervix Invasive	1 in 110
Leukaemia	1 in 164	Uterus	1 in 104
Melanoma	1 in 303	Melanoma	1 in 179
		Cervix In-Situ	1 in 63

A total of 240 cancer cases (107 males and 133 females) were registered in Jersey in 1989. Of these, 155 cases were registered at death and 85 were living at the time of registration, but it should be noted that the majority of cases were not diagnosed during 1989.

TABLE III — 1

Analysis of all cancer cases registered in 1989

		Males	Females	Totals
BUCCAL CAVITY & PHARYNX 140 — 149				**8**
141	Tongue	1	—	1
144	Floor of mouth	1	1	2
145	Other & unspecified parts of mouth	1	—	1
146	Oropharynx	1	1	2
147	Nasopharynx	—	1	1
148	Hypopharynx	—	1	1
DIGESTIVE ORGANS AND PERITONEUM 150 — 159				**61**
150	Oesophagus	4	4	8
151	Stomach	8	2	10
152	Small intestine, including duodenum	2	—	2
153	Large intestine, except rectum	8	8	16
154	Rectum and rectosigmoid junction	3	6	9
155	Liver & intrahepatic bile duct, specified as primary	3	1	4
156	Gallbladder & bile duct	—	1	1
157	Pancreas	6	4	10
158	Peritoneum and retroperitoneal tissue	1	—	1
RESPIRATORY SYSTEM 160 — 163				**50**
160	Nose, nasal cavities, middle ear & accessory sinuses	1	—	1
161	Larynx	4	2	6
162	Trachea, bronchus and lung	20	23	43
BONE, CONNECTIVE TISSUE, SKIN AND BREAST 170 — 174				**49**
172	Melanoma of skin	—	1	1
173	Other malignant neoplasm of skin	10	8	18
174	Breast	—	30	30
GENITO-URINARY ORGANS 180 — 189				**42**
180	Cervix uteri	—	4	4
182	Other malignant neoplasm of uterus	—	7	7
183	Ovary, fallopian tube and broad ligament	—	7	7
184	Other and unspecified female genital organs	—	2	2
185	Prostate	12	—	12
186	Testis	1	—	1
187	Other and unspecified male genital organs	2	—	2
188	Bladder	2	1	3
189	Other and unspecified urinary organs	3	1	4
OTHER AND UNSPECIFIED SITES 190 — 199				**13**
191	Brain	4	2	6
199	Malignant neoplasm without specification of site	2	5	7
LYMPHATIC AND HAEMATOPOIETIC TISSUE 200 — 209				**17**
200	Lymphosarcoma & reticulum-cell sarcoma	1	—	1
201	Hodgkins disease	—	2	2
202	Other neoplasms of lymphoid tissue	2	4	6
203	Multiple myeloma	—	2	2
204	Lymphatic leukaemia	1	—	1
205	Myeloid leukaemia	3	—	3
207	Other and unspecified leukaemia	—	1	1
208	Polycythaemia vera	—	1	1
Totals		**107**	**133**	**240**

A total of 6,645 cases (3,266 males and 3,379 females) have been registered in Jersey since 1962.

The total number of cases diagnosed at the General Hospital during the past three years is:—

1987 — 138
1988 — 270
1989 — 240

IV

Morning Medical Clinic

A medical clinic is held in the Health Centre wing of the General Hospital every morning, except Sunday, during the "high season" — May to September, and in "low season" on Monday, Wednesday and Friday mornings. It provides a general practitioner-type service for U.K. visitors, other overseas visitors, and also serves a small number of seasonal workers newly arrived in the Island who are not entitled to social security benefit. Hospital staff suffering from acute conditions needing urgent attention, or minor disorders needing short-term care are also seen. The service is free, apart from the charge made for any drugs prescribed.

Many more patients are seen in the months from May to September than in other times of the year, especially during July and August.

A total of 4,645 patients (1,961 males and 2,684 females) were seen in 1989, 245 more than in 1988. Of these 3,898 (83.9%) were visitors, 600 (12.9%) seasonal workers, 112 (2.4%) staff and 35 (0.8%) new residents.

20 (0.4%) patients had to be admitted to Hospital, 65 (1.4%) were referred to other Hospital clinics, 4 (0.09%) were referred for Physiotherapy and 27 (0.6%) were referred to their U.K. General Practitioner for further treatment.

The following table records the analysis of the clinic's work during 1989.

TABLE IV — 1
Analysis of attendance at Morning Medical Clinic
1989

	Jan.	Feb.	Mar.	Apr.	May	JUNE Week commencing				JULY Week commencing					AUGUST Week commencing				Sept.	Oct.	Nov.	Dec.	Totals
						5th	12th	19th	26th	3rd	10th	17th	24th	31st	7th	14th	21st	28th					
SEX: MALES	20	24	40	51	249	60	88	96	78	76	80	76	114	125	85	95	92	55	296	88	35	38	1,961
FEMALES	34	27	48	73	308	101	89	112	119	128	137	145	153	137	126	126	140	89	407	129	29	27	2,684
Totals	54	51	88	124	557	161	177	208	197	204	217	221	267	262	211	221	232	144	703	217	64	65	4,645
TYPE:																							
Seasonal workers	15	19	28	34	86	13	17	31	18	22	28	22	7	29	24	28	21	11	81	29	22	15	600
Visitors	22	13	50	86	458	141	159	177	179	178	185	197	260	229	184	191	208	131	605	179	31	35	3,898
Staff	16	13	8	3	13	7	1	—	—	2	4	2	—	4	1	2	2	1	12	8	7	6	112
New residents	1	6	2	1	—	—	—	—	—	2	—	—	—	—	2	—	1	1	5	1	4	9	35
REFERRALS:																							
Admissions	1	1	1	—	1	—	—	—	1	3	1	—	—	1	1	—	4	—	3	1	—	1	20
G.P. — U.K.	—	—	—	2	1	—	—	—	—	1	3	1	—	—	4	2	2	—	7	4	—	—	27
Other clinics	1	1	5	5	14	3	1	1	2	2	3	5	—	4	2	—	1	1	8	2	2	2	65
Physiotherapy	—	—	—	—	—	—	—	—	—	2	—	—	—	2	—	—	—	—	—	—	—	—	4

V
Immunisation and Vaccination Clinics — 1989

I am indebted to Dr. Gwyn Llewellin for this report and Chapters VI and VII.

International travel clinics were held throughout the year on Tuesday mornings and Wednesday afternoons at the Health Centre, General Hospital, offering immunisation and vaccination for persons travelling abroad.

TABLE V — 1
International travel
Number and type of prophylaxis provided at clinic
1989

Typhoid (monovalent)	1,424
Cholera	288
Tetanus	544
Yellow fever	464
Poliomyelitis	593
Gamma globulin	856
Totals	4,169

Vaccination against Hepatitis "B"
1,965 doses of Hepatitis "B" vaccine were administered in 1989.

Vaccination against Rabies
20 doses of Rabies vaccines were administered in 1989.

Anti-influenza vaccination
17 persons were vaccinated in 1989.

Resources Recovery Board Staff
The following immunisations were given to R.R.B. staff:

Poliomyelitis	116
Tetanus	72
Typhoid	69

VI

Priority Housing on Medical Grounds

There were a total of 165 applications for re-housing on medical grounds in 1989, 32 less than in the previous year.

9 were placed in the immediate category; 36 in the most urgent category and 56 in the urgent category.

TABLE VI — 1

Applications for priority housing on medical grounds
1987 – 1989

	1987	1988	1989
Immediate	6	14	9
Most urgent	52	67	36
Urgent	79	69	56
Less urgent	63	31	40
No recommendation	8	9	21
Others (no decision required)	20	7	3
Totals	228	197	165

VII

Occupational Health

The purpose of an occupational health service is to ensure that the health of men and women at work is not adversely affected by their occupation.

In 1989 there were two major legislative developments which will have implications for the occupational health service viz: the Health and Safety at Work (Jersey) Law 1989; and EEC Directive (89/391/EEC) which introduces measures to encourage improvements in the safety and health of workers at work.

The Occupational Health Service in Jersey

At the present time the senior clinical medical officer provides a service to the majority of States departments.

This consists of:

1. The vetting of medical questionnaires submitted by all new entrants to the Civil Service and Hospital Service.
2. Medical examinations at the Health Centre for:
   - (a) Harbour Pilotage licences (statutory)
   - (b) States and Airport Fire Services
   - (c) Harbour divers
   - (d) Formerly of Air Traffic Control Officers (it is hoped to provide for these examinations again shortly)
   - (e) Prospective teacher training college students (for the Education Department)
   - (f) On request for other States departments.
3. Occupational health guidance for States departments.
4. Opinions given in cases of early retirement on medical grounds.

There is also provision for advice from the Environmental Health Officers and the States' Official Analyst, if required.

In 1989 117 medical examinations were carried out (82 for States Departments; 35 for other organisations).

Future development of the Occupational Health Service in Jersey

The States of Jersey are the largest employers in the Island, employing nearly 6,000 people. The present occupational health service in Jersey is very little more than a 'breakdown and retirement' facility. A large section of States employees — the manual workers — are not covered by the present service.

If the States wish to be seen as a sympathetic and caring employer then the occupational health service must be developed from its present rudimentary form. This obviously has financial, manpower and accommodation implications. To define these requirements and to provide an accurate estimation of the cost of a proper service it would be necessary to study the occupational health service of a similar-sized organisation, e.g. a health authority or an industrial organisation in the U.K.

VIII
Well-Woman Service

I am indebted to Dr. Susan Foster, Senior Clinical Medical Officer, for this report on the Well-Woman Service and Chapters IX, X and XI.

Well-women clinics (previously called early detection clinics) continued to be held three times a week at the Health Centre of the General Hospital.

1,251 women attended for cervical smear examinations in 1989 and, of these, 1,228 (98.2%) proved to be normal, which was the same as for 1988. 14 women were called for a repeat smear and 9 were referred to the gynaecologist for further treatment. 48 women were found to have other gynaecological problems and were referred to their own doctor for treatment as necessary.

1,453 women attended the clinics for instruction in self-examination of the breasts. Their breasts were examined by the clinic doctors and 1,404 (96.6%) were found to have no abnormality but 49 (3.4%) were referred to their own doctor for further investigation, to include a mammogram.

Urine testing and blood pressure checks were also offered at the clinics. 1,055 women had their urine tested and 28 (2.6%) were referred to their own doctor because an abnormality had been detected. Likewise 1,453 had their blood pressure checked and 37 (2.5%) were referred to their own doctor for further checking.

TABLE VIII — 1

Results of Cervical Smears, in Age Groups — 1989

Age Group	Total Seen	Normal Smears			Pre-cancerous condition	
		First -ever	Routine	Post-Menopausal	*C.I.N. I Repeat Smear	*C.I.N. II Gynaecological Referral
Under 25	34	21	12	—	1	—
20 – 24	79	23	56	—	—	—
25 – 29	92	17	73	1	1	—
30 – 34	130	16	109	2	3	—
35 – 39	157	10	144	1	—	2
40 – 44	227	10	208	1	6	2
45 – 49	160	3	147	5	2	3
50 – 54	168	2	116	49	—	1
55 – 59	160	1	39	119	1	—
60 – 64	37	—	6	30	—	1
65 and over	7	1	2	4	—	—
Totals	1,251	104	912	212	14	9

* C.I.N. = cervical intraepithelial neoplasia.

TABLE VIII — 2

Breast Examinations — 1989

Age Group	Total Seen	Referred to GP
Under 20	29	—
20 – 29	144	1
30 – 39	283	11
40 – 49	393	22
50 – 59	326	8
60 and over	278	7
Totals	1,453	49

IX
Family Planning Service

Family planning clinics continued to be held three times a week at the Health Centre of the General Hospital, and a total of 1,444 persons were seen. Clinic attendance over the last five years, as shown in Table I, has been falling, which is rather worrying.

Table 2 shows the attendances broken down into age groups, local residents or seasonal workers, and treatment given; with the 'pill', as usual, being the most popular method.

The charge for an ordinary visit to the clinic was £4.00 and £25.00 for a coil insertion. A totally free service is provided at the clinics on medical/socio-economic grounds. Applications are made via the health visitors to the Medical Officer of Health, but only 33 women took advantage of this free service in 1989.

TABLE IX — 1

Clinic attendances 1985 – 1989

Year	New	Re-attendances	Total
1985	315	1,560	1,821
1986	353	1,409	1,762
1987	315	1,256	1,571
1988	334	1,280	1,614
1989	288	1,156	1,444

The following table shows attenances broken down into age groups, local residents or seasonal workers, and treatment given:

TABLE IX — 2

Age groups	Resident	Seasonal	Pill		Coil	Cap	Discussion
			Combined	Mini			
Under 19	135	40	158	2	—	4	11
20 – 24	343	85	377	12	8	8	23
25 – 29	342	35	268	13	29	42	25
30 – 39	392	5	251	51	35	33	27
40+	67	—	15	30	11	6	5
Totals	1,279	165	1,069	108	83	93	91

X
Pre-school health service

The pre-school health service continued to provide routine developmental medical examinations for children, aged between three years and four and a half years, who attended the 37 registered nursery/play groups; including the 4 nurseries in primary schools. Children not attending these groups were seen at developmental clinics run by clinic doctors and health visitors for similar three and four year old assessments.

Parental attendance and interest at the time of these medicals remained good and a total of 772 children were seen, an increase over last year. 10% of these children needed to be reviewed again the following year, and about the same number needed to be followed up at the Health Centre for defects in vision, hearing, speech and developmental skills.

65 children (8%) were already attending a hospital specialist, and 126 children (16%) needed direct specialist referral — as shown on Table X-2. Most of the referrals, as usual, were to the ophthalmic, E.N.T. and speech therapy clinics. The ophthalmic referrals were for refractive errors and suspected squints, and the E.N.T. referrals were for hearing defects mainly due to 'glue ears'.

Immunisation against diphtheria, whooping cough, tetanus, polio, measles, mumps and rubella were discussed at the time of the medical examinations, and parents were encouraged to ensure that their children were up-to-date with the necessary immunisations, particularly the new M.M.R. vaccine (measles, mumps and rubella). Children not born in Jersey and who therefore had not received B.C.G. at birth were advised to attend the Health Centre immunisation clinic for Heaf testing and B.C.G. vaccination.

The health visitors maintained their valuable support in providing relevant background information on children seen, and carried out follow-up home visits where necessary. Various aspects of health education were discussed at the nurseries, and mothers were encouraged to check their children's hair weekly for evidence of head lice infestation, and to treat with Derbac M lotion when found.

My thanks are due to Dr. Milner, the part-time medical officer who has helped me with the medicals, and to the matrons and supervisors of the playgroups and nurseries for their co-operation.

TABLE X — 1
Children examined at nurseries 1985 – 1989

	1985	1986	1987	1988	1989
Total number of children examined	635	683	782	705	772
Children without defects	450	476	540	341	433
Children with defects followed up at the Health Centre clinics and/or needing specialist referral	103	122	128	215	195
Children to be seen again next year	40	32	43	77	79
Children already attending a specialist	42	53	71	72	65

TABLE X — 2
Medical Examinations
1980 – 1989

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Total number of children examined	**667**	**600**	**634**	**687**	**639**	**635**	**683**	**782**	**705**	**772**
Children requiring specialist referral										
E.N.T. clinic	11	11	8	11	11	12	13	18	23	35
Ophthalmic clinic	28	13	14	10	19	13	17	15	26	40
Paediatric clinic	—	—	1	3	3	2	1	1	2	2
Surgical clinic	—	—	1	4	2	1	4	5	1	2
Speech therapist	24	20	14	36	32	32	40	34	24	23
Educational psychologist	3	2	—	2	6	2	—	6	7	8
General practitioners	15	11	14	11	11	7	12	11	15	16
Total numbers	**81**	**57**	**52**	**77**	**84**	**69**	**87**	**90**	**98**	**126**
Percentage of total numbers of children examined requiring specialist referral	12%	9.5%	8%	11%	13%	11%	12.5%	11.5%	14%	16%

XI
School health service

The school health service continued to provide routine and selective medical examinations and routine immunisations and vaccinations in all schools in Jersey during 1989.

Although the total school population has continued to fall during the last three years to 9,856 in 1989, the percentage of children examined in schools increased to 30% (3,017 children).

All infants in their first year of school have a medical examination and, in 1989, this number increased to 887 compared with 870 in 1988. Likewise, the number of 10 year old juniors selected for a medical examination increased to 269 (251 in 1988). All seniors in their third year have a medical examination, and 800 were examined (813 in 1988).

The number of special examinations increased to 1,061 (755 in 1988), and these included children of all ages needing routine follow-up examinations from the previous year, in particular vision and hearing tests; or who had recently come to live in Jersey; or specially requested by parents or school staff.

The numbers of defects found during examination showed only slight changes from recent years, and the percentage of children who needed specialist referral was similar to last year at 6.8% (207 children). These referrals included 110 children to the optician, 23 to the eye clinic, 25 to the E.N.T. clinic, and 3 to the speech therapist (see Table XI-3).

In addition, 466 10-year old children not selected for medical examinations had routine vision tests, of which 20 were referred to the optician (see Table XI-4).

Routine audiometric screening tests for hearing were carried out on 2,992 children, and 362 (12%) were found to have hearing defects. 53 children required follow-up audiograms at the Health Centre, of whom 25 were referred to the E.N.T. clinic, whilst 91 children were already attending this clinic with a known hearing defect. 161 children will need a repeat audiometric test next year as they either had only a slight hearing defect or were absent for testing.

Children with chronic medical conditions such as epilepsy and diabetes were seen on an annual basis. 13 such children were seen with epilepsy, 8 with diabetes, 2 with chronic heart conditions and 111 with an asthmatic history. Also, children with severe physical or mental handicaps or behavioural problems are seen annually. A Review Panel, consisting of representatives from the Education and Public Health departments continued to meet once a term to discuss their management, which includes admission or transfer of these children to special schools or classes. A small number of seriously handicapped children still attend special schools in the United Kingdom.

A retrospective survey was carried out on the number of five year old children who had attended playgroups and nurseries, and had received their 3-4 year old developmental assessments and their necessary immunisations for measles and whooping cough. Table XI-6 shows that 749 children (84%) had attended nursery groups and 80% had had these assessments. However, only 54% had their measles immunisation and 62% their whooping cough immunisations, which was disappointing.

Diphtheria, tetanus and polio boosters and the new measles/mumps/rubella vaccine (MMR) were offered to infants at the 5-year old school medical examination, and tetanus and polio boosters to seniors at their 13-year old school medical examination, as shown in Table XI-7. Also 493 girls aged between 11-12 years received rubella vaccinations. Of the 13-year olds, 752 had Heaf skin tests to determine their resistance to tuberculosis, and 165 were given BCG vaccination as they showed no resistence (71 of these had not been vaccinated at birth, as shown in Table XI-8). 1,065 babies were given BCG vaccination in the first few days of life and, since BCG was introduced into Jersey in 1949, a total of 48,476 individuals have been vaccinated.

Enuretic alarms were used by six children to help treat their nocturnal enuresis (bed wetting). Three children showed some improvement, but three remained enuretic.

Head infestations continue to be a problem and the school nurses were available to advise parents and school staff on the necessary treatment and inspect heads when there was a particular outbreak. Leaflets, obtained from the Public Health Department, were distributed to parents advising them to check their children's hair weekly for evidence of infestation. Derbac M (malathion lotion) became the treatment of choice for 1989. It is necessary to change the insecticide every three years to prevent resistance building up.

Health education continued to be of great importance in all schools, with teachers, pupils and parents receiving regular advice and information on all aspects including drug and alcohol abuse, smoking, contraception and AIDS, co-ordinated by the Health Education Officer.

TABLE XI — 1
Medical examinations 1987 – 1989

	1987	1988	1989
Pupils on school registers	10,224	10,199	9,856
Children examined	2,710	2,690	3,017
Percentage of children examined	26.5	26.1	30.6
Children without defects	—	1,159	1,262
Children with defects known or to be rechecked	—	1,346	1,537
Children with defects requiring specialist referral	246	185	218
Absentees	117	104	101
Refusals	38	35	29
Medical Officer sessions	253	234	276

TABLE XI — 2
Number of children examined, classified by age group — 1989

Age groups	Number examined
Infants (aged 5+)	887
Juniors (age 10)	269
Seniors (age 13+)	800
Special examinations	1,061
Total	3,017

TABLE XI — 3
Number of defects requiring specialist referral found during periodic and special examinations, distributed by age groups

	Periodic examinations					Incidence of defects per 1,000 children
Referrals to:—	Infants	Juniors	Seniors	Special examinations	Totals	
G.P.	18	12	15	12	57	—
Skin clinic	—	—	—	—	—	—
Optician	1	29	37	43	110	36.4
Eye clinic	13	2	2	6	23	7.6
E.N.T. clinic	11	4	3	7	25	8.2
Speech Therapy	2	1	—	—	3	0.9
Totals	45	48	57	68	218	

TABLE XI — 4

Number of 10 year old children not selected for medical examination who had vision tests during 1989

Number tested	No. without defect	No. with defect	Number referred
466	228	238	20

TABLE XI — 5

Audiometric Screening Tests

Infants (5+yrs)		Juniors (10yrs)		Seniors (13+yrs)		Special examinations		Rechecks	
Number examined	Number defects	Number examined	Number defects	Number examined	Number defects	Number examined	Number defects	Number examined	Number defects
929	83	778	95	808	42	270	78	207	64
Percentage of defects in 1989									
	9%		12%		5%		28%		30%

TABLE XI — 6

Retrospective survey of number of 5 year old children who attented pre-school nursery groups, and had examinations & immunisations

Total No. of children	Attended nursery	3/4 yr exam at nursery	3/4 yr exam. at health visitor cl.	Measles immun.	Whooping cough immun.	M.M.R. immun.	Measles disease	Whooping cough disease
887	749	657	59	484	546	49	9	—

TABLE XI — 7

Immunisations/vaccination during 1989

Places	Age	Immunisations/ vaccinations	Number of children
Maternity Unit	Newborn	B.C.G.	1,065
Infant welfare clinics	1st yr. of life	Primary course of diphtheria/tetanus/ whooping cought & polio	713
Infant welfare clinics	1st yr. of life	Primary course of diphtheria/tetanus & polio	91
Infant welfare clinics	Pre-school	Measles/Mumps/Rubella	540
Schools	5 years	Measles/Mumps/Rubella	440
Schools	5 years	Diphtheria/tetanus booster	1,039
Schools	5 years	Polio booster	1,046
Schools	11+ years	Rubella (girls only)	493
Schools	13+ years	Tetanus booster	1,074
Schools	13+ years	Polio booster	1,122
Schools	13+ years	B.C.G.	165

TABLE XI — 8

1989 — Summary of Heaf (tuberculin) test results (13+ year old school children)

Reaction in previously B.C.G. vaccinated pupils						Reaction in unvaccinated pupils					
Negative	**1**	**2**	**3**	**4**	**Total**	**Negative**	**1**	**2**	**3**	**4**	**Total**
74	25	450	3	—	552	71	7	120	2	—	200

XII
School Dental Service

I am indebted to Mr. John Fleet, Consultant Oral/Dental Surgeon, for this report on the School Dental Service:

The major improvement in the School Dental Service in 1989 has been the establishment of the Dental Health Educator, Mrs. Margaret Leando. Her activity has been in many areas in the community to get the message over that dental decay and gum disease are preventable. They can be prevented by the use of safe snacks, tooth brushing and fluoride, both as toothpaste and as a dietary supplement for the growing child. She has been active in educating mothers, health visitors and teachers, as well as children in the primary and secondary schools. She has campaigned for sugar-free medicines and contacted all doctors and pharmacists and given them advice and literature.

It is a pleasure to acknowledge the support she has received from head teachers and all health care workers to get over this most imporant message that dental disease is totally preventable.

That dental health education works was shown by the follow-up of 5 year olds in 1989, who had two years of dental health education in their playgroups in the Jersey Happy Smilers Campaign. The Birmingham Survey of 1987 showed the average 5 year old in Jersey had 1.56 decayed, missing or filled teeth. After two years education this has fallen to 0.83, a halving of the 1987 figure. This is very encouraging and must be continued. There is no reason for any child to have dental decay and it is a failure on the part of the parents and child when this happens. The School Dental Service cannot provide treatment for all children without a great increase in staffing. Prevention is the only hope for the future.

During 1989 the Public Health Committee helped the routine dental treatment by a temporary increase in staff of 0.6 sessions per week. This is reflected in the increased fillings and extractions noted in the Annual Report. It must be borne in mind that the present staff of 1.6 dentists for routine dentistry is totally inadequate for the care of 12,000 children. The U.K. recommendation for this number of children is 5 dentists.

With almost 40% of all children seen at school inspections needing treatment, it is an impossible task; not helped by the 20% of all children who fail to keep appointments. This contrasts with referral to the Consultant Dental Surgeon of adults and children, where failure to attend is less than 2%.

It is regrettable that trends in the U.K. could not be mirrored in Jersey, encouraging all routine dental treatment of children to be under the care of the private dental practitioner, so encouraging family dental responsibility. The hospital dental service could them become a specialist back-up providing oral surgery and orthodontics as well as routine dental treatment for the physically and mentally handicapped if they are too difficult to treat in dental practices. Original plans for this via a capitation system were rejected by the Jersey Dental Association. Perhaps the introduction of the new dental benefit scheme for 16-21 year old school leavers will begin a system which could be extended to other age groups.

TABLE XII — 1

School Dental Service 1989 — Attendances and treatment

	1989
Inspections at school	3,660
Number needing treatment	1,317
First visits	3,209
Total attendances	8,691
Total fillings	4,663
Teeth filled (permanent)	3,731
Teeth filled (deciduous)	932
Visits for orthodontic treatment	3,263
Removable appliances	551
Fixed appliances	672
Out-patients general anaesthetics	160
Patients treated by hygienist	482
Patients seen by consultant orthodontist	213

XIII
Speech therapy service

I am indebted to Miss Anne Lowry, Chief Speech Therapist, for this report on speech therapy services for 1989.

The demand made on the Speech Therapy Service continues to exceed supply, although the quality of service given by the team has been noticeably enhanced by the welcome appointment of Julia Hare in February, 1989. She has become an essential and integral contributor and this contribution has been particularly noticeable in the area of children with special needs at Mont à l'Abbé School, which now has nine sessions per week.

The following table shows the overall allocation of sessions:

TABLE XIII — 1
Number of Sessions

Venue	No. of weekly Sessions		Patient Group	Type of Disorder
	1988	1989		
Health Centre General Hospital (Ward & Out-patients)	18	18	Pre-School & School children Adults	Language — e.g. Stroke/Delay Articulation — e.g. Delay/M.S.
Communicare	3	3	Mostly Children & Adults	Voice — e.g. Laryngectomy/ Cleft Palate
Poplars Day Centre/ William Knott Day Hospital	6	6	Mostly Adults & Children	Fluency — e.g. Stammer/ Parkinsonism
Overdale Hospital Ward Patients	—	3	Adults	Swallowing — e.g. Stroke/ Head Injury
Mont à l'Abbé School	9	9	Children	Special Needs (Mental Handicap)
Bel Royal School	2	2	Children	Physical Handicap
Rouge Bouillon School	1	1	Children	Hearing Impairment
Le Geyt Centre	1	1	Adults	Special Needs (Mental Handicap)

TABLE XIII — 2

Number of pre-school and school age children seen 1984 — 1989

No. of Therapists	Year	Pre-school		School age		Total	
		M	F	M	F	M	F
2	1984	331	280	1,143	780	1,474	1,060
3 (1 Extra in October)	1985	388	296	1,330	934	1,718	1,280
3	1986	619	230	1,403	918	2,088	1,148
3	1987	642	289	1,392	970	2,034	1,259
4 (1 Extra in July)	1988	774	353	1,527	1,005	2,301	1,358
4.2 (Extra Sessions in July)	1989	881	438	1,443	1,381	2,324	1,819

TABLE XIII — 3

Number of children seen 1984 – 1989

	1984	1985	1986	1987	1988	1989
Patients treated	284	303	314	321	341	408
Attendances	2,534	2,948	3,170	3,293	3,659	4,143

TABLE XIII — 4

Number of Adult Attendances 1984-1989

No. of Therapists	Year	Patients		Total
		M	F	
2	1984	786	397	1,183
1 extra in Oct.	1985	740	462	1,202
3	1986	968	815	1,783
3	1987	1,063	981	2,044
1 extra in July	1988	1,104	1,019	2,123
2 extra in June	1989	1,191	1,125	2,316

A speech therapist whose services were available to the Department on a voluntary basis from February to July, 1989, worked on a number of projects, including setting up a programme for the residents and staff of Cherry Lodge to help communication, feeding and swallowing. Speech therapy input at Le Geyt Centre was examined in some depth. The conclusion was that as the provision stands, at one session per week, its value is limited. Adults with special needs require a great deal more speech therapy time than this to organise, assess, advise carers and plan appropriate treatment.

The introduction of speech therapy for 2-3 sessions per week at Overdale Hospital since August, 1989 has been invaluable. This includes a weekly multi-disciplinary meeting on Samares Ward. Patients are drawn from the wards at Overdale, and from William Knott Day Hospital when they make enough progress to go there. The workload is such that some patients are unable to benfit from more intensive therapy.

An evening class was set up at Highlands College for drama and conversation with adults with special needs, and this was a most successful venture. The Signing course at Highlands College continued for two terms in 1989, and in January a most successful two-day Makaton Signing course was held at the General Hospital.

I obtained a Diploma in Hypnotherapy and N.L.P. (Neurolinguistic Programming) following a course in London. The skills acquired are being used most successfully to expedite treatment of patients with voice, fluency and language disorders, as well as in general working communication with colleagues and other professionals.

Two meetings, held in Jersey in May and in Guernsey in October, were arranged with the four Guernsey speech therapists. This important link is strengthening and maturing and is a means of mutual support, encouragement and furthering our professional knowledge and experience.

Lecutures were given to (a) participants on the Pre-School Playgroup supervisors' course; (b) student nurses in small groups, who also had the opportunity to observe a speech therapist at work during a clinical session; (c) trained professionals as part of the English National Board course for Nursing Elderly People; and (d) occupational therapists, physiotherapists and helpers at William Knott Day Hospital. More informal talks were given to parent groups, and associations such as the Parkinson's Disease Society.

XIV
Environmental Health

I am indebted to Mr. A. Littlewood, Chief Environmental Health Officer, for this report on the Environmental Health Service.

INTRODUCTION

1989 was again a year of change and also consolidation for the Environmental Health Section. It was also a frustrating year in that the reactive work of the department appeared to increase to the detriment of the pro-active work which is so essential in compiling a data base on environmental matters which would allow the department to monitor trends and to deal more confidently with the environmental issues which face us today.

The staffing situation in the department was slightly improved with the appointment of Mr. Stephen Sands as an Environmental Health Assistant from the 30th May, 1989.

Miss C. Rossi, Trainee Environmental Health Officer, is at present carrying out practical training with Mole Valley District Council in the U.K.

MANAGEMENT

The section continues to operate in three main areas of environmental health:

a. consultation.
b. education.
c. enforcement.

The education and preventive function by way of food hygiene courses was continued during 1989 and the staff were involved in lecturing to personnel of local catering and food establishments to basic food hygiene certificate standard.

The section continued to seek a high profile through the Jersey Evening Post, BBC Radio Jersey and Channel Television and by this method we have highlighted the important contribution that an efficient and effective environmental health section can make to the health of the general public in the work, home and recreational environments.

There is still a need within the department to move from a reactive mode of operation to a pro-active or routine base and the need to monitor the environmental situations which affect our Island's environment both on land, in the air and in the sea.

It is extremely important that the section achieves and maintains a high standard of service and promotes a positive and forward looking approach to communicating the environmental health message to all people involved in Island life. This is by no means an easy task with the limited resources available to the Environmental Health Section.

FOOD CONTROL

Food hygiene and food safety continues to be a high priority function within the Environmental Health Section since the figures for reported food poisoning cases in the U.K. have continued to rise and this has been mirrored in Jersey. In fact, it is of great concern to the Island Authorities since 1989 demonstrated the highest figures ever recorded in the Department for food poisoning.

Inspection of food premises under the provisions of the Food and Drugs (Jersey) Law, 1966 and the Food Hygiene (General Provisions) (Jersey) Order, 1967 continued. The majority of work was concentrated in the private sector but a close liaison was maintained with the public sector and the Department continued to monitor the Jersey Group of Hospitals in relation to the hospital kitchens and the cook-chill system which is operational but is being modified.

The Law relating to food and the effect of the provisions of EEC Directives is constantly under review.

The fact that Jersey is not a full member of the EEC does not mean that such provisions do not impact upon the work of this Department and indeed in this area more work is being generated for the officers.

The Environmental Health Section organised a Food Hygiene and Food Safety Seminar in November aimed at the management of catering establishments, hotels, restaurants, retail and wholesale outlets which was attended by some 200 + delegates. Papers were presented by both U.K. and local speakers.

ROUTINE FOOD SAMPLING

Investigation of food complaints continued and the section's activities are listed in tables 1 and 2 below.

TABLE XIV — 1

Routine sampling of foods

	*Purpose	Samples taken	Unsatisfactory	Remarks
Whole milk	CC	63	3	Later samples satisfactory
Fat reduced milk	CC	63	1	
Semi-skimmed milk	CC	63	Nil	
Skimmed milk	CC	63	1	
Whole milk	QP	63	Nil	
Fat reduced milk	QP	63	Nil	
Semi-skimmed milk	QP	63	Nil	
Skimmed milk	QP	63	Nil	
Goats milk soft cheese	QB	4	Nil	
Sandwich Packs	QB	4		No Standards set
Jersey Gold Double Cream	CC	1	Nil	
Oysters	QB	13	1	Later sample satisfactory
Oysters	RA			
Oysters	RA			
Paloudres	QB	1	Nil	
Milk raw unprocessed	RA	76	Nil	

*Purpose:
Constituent/Composition = CC
Quality/Pasteurisation = QP
Quality/Bacteriological = QB
Radioactivity = RA

TABLE XIV — 2

Unfit foods — complaints

	Bakery Products	Meat	Meat Products	Milk/ Milk Products	Other Tinned Pkt foods	Take-away foods	Fruit/ vegetables	Fish	Total	1988
Foreign bodies	12	—	—	3	26	11	—	1	53	61
Not of nature or quality demanded	6	2	1	—	12	3	—	—	24	12
Decomposition/Mould	2	1	—	1	8	—	—	2	14	22
Complaints not upheld	7	2	—	4	24	5	4	1	47	23
Still under investigation	6	—	—	—	4	1	—	—	11	—
Totals	32	5	1	8	74	20	4	4	149	118

Four of this years complaints have resulted in court action:-

A sandwich company was fined £200 after used first-aid plasters were found in one of their sandwiches.

A generalised and neglected infestation of moths in a shop allowed larvae to infest displayed foodstuffs and the Company was fined £150 for selling a Health Food Bar infested with the larvae.

A bakery was fined £150 when a razor blade was found attached to the base of a loaf of bread. The staff were continuing to use double edged safety razor blades for slicing across the top of the dough prior to baking, following the loss of protected blade holders. It is believed that this particular blade was laying on the preparation table and was picked up by the bread dough being placed upon it.

The fourth case was found not proved by the magistrate. This involved the sale of mouldy cheese and the display of mouldy cheese. The Company had previously been advised of the risk of selling mouldy cheese when they allowed blocks of cheese waiting to be cut and sold on demand, to develop mould growth.

GASTRO-INTESTINAL DISEASE

1989 statistics relating to infectious gastro-intestinal disease were alarming and Jersey reflected the upward trend which was being experienced globally. During the year the section dealt with 125 incidents, 100 being sporadic (one case only) and 25 being classed as outbreaks (two or more cases) and of these outbreaks five related to hotels or restaurants. One outbreak at a hotel resulted in 64 recorded cases both in Jersey and the U.K. The total number of cases in the outbreaks was 183 and the total cases in all incidents totalled 283. A further 445 people were monitored and investigated as close contacts or known cases.

Table 3 below relates.

TABLE XIV — 3

Summary of intestinal infectious disease investigations	**1986**	**1987**	**1988**	**1989**
Incidents	63	72	70	125
— Sporadic (1 case only)	48	54	53	100
— Outbreaks (2 or more cases)	15	18	17	25
Total cases in outbreaks	92	57	70	183
Total cases in all incidents (Case = ill and/or positive specimens)	140	111	123	283
Persons involved in all incidents ("involved" = investigated and/or at close risks i.e. contacts, family plus "cases")	236	329	487	445

The section has reacted to these bad figures by reviewing its procedures and service.

Educational courses in food hygiene continue to be promoted and a closer liaison with the Catering and Leisure Services Department at Highlands was forged. A Seminar on Food Hygiene and Food Safety was organised by the Public Health Committee supported by Tourism and Education Departments. Education of food handling personnel and inspection of premises is manpower intensive and if this extremely worrying problem is to be tackled then resources in the form of manpower must be found. This is an investment in the future of the Island and the Tourism industry. Failure will have a devastating effect upon the tourist and catering trade and the economy of the Island. Prevention should be paramount in the promotion of environmental health and a long term policy of "spend now — save later" would be wise counsel.

DRUG SAMPLING

During 1989 the Public Health Department, the Social Security Department and the Official Analyst co-operated in a drug sampling scheme. The scheme's objective was to provide a quality control testing of medicines available under the Health Scheme within the Island as an additional reassurance to the general public, pharmacists, doctors and other States Departments.

Medicines/Drugs were selected at random from the prescribed list to be sampled on a monthly basis and samples would be obtained from stock held for dispensing health scheme prescriptions at approved suppliers. Samples were analysed with reference to the British Pharmocopoea monograph. The scale of sampling was up to five drugs each month, priority given to generic products.

The scheme was introduced in March, 1989 and during the year ending 31st December, 1989 forty-six items were sampled. Reports received to date from the Official Analyst indicate all conform to their respective standards.

HOUSING AND DEVELOPMENT CONTROL

During 1989 three properties were the subject of action by the Public Health Committee in accordance with the provisions of Section 2 (2) of the Loi (1934) sur la Santé Publique, as follows:—

Demolition Order	
"Fareham", La Grande Route des Sablons, Grouville	13.12.89
Closing Order	
"Wayfaring", Gorey Coast Road	24.1.89
Part "Homestill", St. Peter	13.12.89

With regard to "Homestill", the whole property is now subject to Closing Orders.

The review of the current list of Closing Orders was completed and an up-to-date list has been compiled.

DEPARTMENT SEARCHES

The fee for property searches was raised from £15 to £20, and was designed to cover administrative costs in researching departmental records. £7,540 was raised.

IDC LIAISON

The twice weekly visits to the Island Development Committee continued and the following table details the extent of the involvement of the Environmental Health Section in plan scrutiny.

Total Applications	2,963	Designated Premises 851
Plans applicable to Public Health	384	
East district	137	
Central district	118	
West district	129	

The section's involvement relates mainly to catering and food premises, but there has been a noticeable increase in the involvement of the section with Lodging House and seasonal workers accommodation. However, we do retain the right to scrutinise and comment upon any application which has an environmental health impact.

SERVICES AND POLLUTION CONTROL

Once again public awareness concerning environmental issues which may adversely affect their lives continues to increase and this has led to a steady growth in the enquiries being made of the Environmental Health Section. Areas of particular interest include:-

a. foul drainage, including extension of mains services;

b. water quality, both chemical and bacteriological;

c. noise control;

d. atmospheric pollution;

e. pollution due to sewage discharges, etc.

f. monitoring of the marine environment (bathing beach quality and radioactivity);

g. pest control.

WATER SUPPLY

This area of environmental monitoring remains a priority and a concern for the section. Private domestic supplies including bore hole, well, springs, rain water catchment and tankered water supplies continue to be sampled for compliance with chemical and bacteriological criteria. Sampling is predominantly on a reactive basis although a limited routine sampling programme has been started. This area of activity requires to be developed as a matter of urgency and a corporate approach to the Island Water resources, both in quality and quantity must be encouraged.

The nitrate content of water is again causing concern. The samples which failed to satisfy bacteriological standards were slightly reduced over the year but there was an increase in chemical samples failing to meet WHO criteria. The main significance of nitrate in drinking water still relates to the condition Infantile Methaemoglobinemia, and where nitrates are excessive, a blanket recommendation continues to be issued advising the use of an alternative lower nitrate water in feeds for babies under six months of age. Similar advice is given in relation to high sodium levels in drinking water.

Liaison continued with the Department of Agriculture on the sampling of wells for the presence of aldicarb and oxamyl. This monitoring exercise provides valuable information in relation to private bore holes and wells.

Details of the results of analysis of samples taken by the section are given in table 4.

TABLE XIV — 4

Summary of the departmental water sampling activities

Samples taken for:	Satisfactory	Un-satisfactory	Total
Bacteriological examination	675	143	818 Inclusive of repeat samples
Full Chemical analysis	454	296	750

Sources sampled:		Samples with excess:		
Wells (dug)	176	Lead	14	
Springs	21	Iron	31	
Streams	3	Copper	20	
Rainwater	19	Zinc	2	
Bore tubes	380	Nitrate	259	See breakdown
Mains supply	10	Manganese	54	of these figures
		Sodium	60	in table below

The nitrate figures can be broken down as follows:—

	WITHIN W.H.O. AND E.C. LIMITS	ABOVE E.C. LIMITS & BELOW W.H.O. LIMITS	ABOVE W.H.O. NITRATES LIMITS
Bore	120 (32%)	176 (46%)	84 (22%)
Well	50 (30%)	72 (44%)	42 (26%)
Springs	3 (16%)	11 (58%)	5 (26%)
Total	173 (31%)	259 (46%)	131 (23%)

DRAINAGE AND SEWAGE DISPOSAL

The Section maintained its activity as a contributor to the Sewer Working Party which determines the areas to benefit from the extension of main drainage services. By applying various environmental criteria the section allocates a degree of priority to each area. Currently there are in excess of sixty areas which the section has pinpointed for future sewer extensions.

During 1989 the following sewer extensions were commenced and/or completed.

1. Greve de Lecq — commissioned.
2. Trinity Phase 1 — commenced.
3. Longueville Court — Minor sewer extensions completed.
4. Clos de la Bliase, Mont Cochon — Sewer extension completed.

The five-year rolling programme relating to sewer extensions was maintained, but at the last meeting of the Sewer Working Party it was noted that an urgent review was being carried out of the existing sewer network to ascertain its capacity to continue to accept an increasing sewage load and also to determine the "pinchpoints" which would need to be addressed if the extension programme was to maintain its forward momentum.

CONSERVANCY SYSTEMS

These systems including septic tanks and soakaways, treatment plants and soakaways and tight tanks are still used extensively on the Island and from time to time give rise to concern mainly due to the failure of the soakaways.

During 1989 the section has liaised closely with the Island Development Committee and the Resources Recovery Board in order to abate nuisances and danger to health arising as a result of surcharges from failing or overloaded systems.

The environmental health section supports the Island Development Committee's policy SE4, as stated in the Island Plan, that new development will not be permitted on conservancy systems unless exceptional circumstances apply. It is important to the sewer extension programme that this policy is maintained and that the two policies run in parallel.

POLLUTION IN AIR

The section continues to be involved in the sampling of air quality and has the capacity to test environmentally sensitive areas for particulate lead and for other pollutants such as carbon monoxide.

POLLUTION — NOISE CONTROL

Environmental noise control observations are made on planning and development application within the aircraft noise zones with particular reference to insulation standards. The section has commented on the standards of noise insulation required particularly where work on rock faces adjacent to nearby domestic buildings was to be carried out.

RADIOLOGICAL MONITORING

The monitoring programme in conjunction with other Island authorities continued throughout 1989. The section continued to sample seaweed on a quarterly basis from the north coast. On an annual basis sediment is collected from St. Helier Harbour and limpets, crab meat and oysters are sampled in order to monitor possible increases in the food chain. Concentrations of Caesium — 137 in fish and shellfish were low and similar to those of previous years. The presence of transuranics and ruthenium — 106 may be attributed to discharges from the plant at Cap de la Hague. However the concentrations were of negligible radiological significance.

RADON

The National Radiological Protection Board are to revise the existing action level for radon in homes from 400 bq/m^3 to 200 bq/m^3 and are also recommending that surveys should be made where there is a 1% probability or more of present or future homes being above such levels. Of the preliminary survey carried out in Jersey, 3 houses would be above the proposed new level. A second survey extending over a 9 month sampling/monitoring period commenced in June. Twenty-five properties have been selected based upon the results from the preliminary survey and when the results of this survey are available consideration will be given to further liaison with the IDC concerning any necessary changes to building regulations/byelaws for new development. Owners of properties with levels detected above action level will be advised on remedial measures required.

TABLE XIV — 5

Sampling Station	Material	Analysis	No. of Analyses
La Rozel	Fucus serratus	(a) Total beta and gamma spec.*	4
	Limpets	(a) Total beta and gamma spec.* (b) Transuranics	4
Greve de Lecq	Porphyra	(a) Total beta and gamma spec.*	4
St. Helier	Sediment	(a) Total beta and gamma spec.* (b) Transuranics	1
Ecrehous	Crabs	(a) Total beta and gamma spec.* (b) Transuranics	1
	Seawater	(a) Caesium radionuclides	4
La Rocque	Oyster	(a) Total beta and gamma spec.*	1
		(b) Transuranics	1
St. Catherine's Bay	Seawater	(a) Caesium radionuclides	4
Verclut	Laminaria	(a) Total beta and gamma spec.*	4

*spec. = Spectrometry

BEACH SAMPLING

One of the requirements of the European Blue Flag Scheme is that the beach must pass the EEC Bathing Water Standards. There are directions on the frequency of sampling and the standards which must be met. To date this Department has only been able to manage minimal sampling owing to the lack of laboratory facilities for bacteriological analysis. It is hoped that these difficulties may be overcome in the future. The sampling activities that have been done, have mainly concentrated on St. Aubin's Bay in relation to the present short RRB sewage outfall pipe. Generally samples have been satisfactory and in compliance with the EEC Regulations but failures to meet the standard have occurred in the immediate vicinity of the sewage outfall pipe.

PEST CONTROL

During the year, Mrs. C. Ward and Mr. Sands, EHA's, attended the British Pest Control Association residential course and examination, on the completion of which, both were awarded the Diploma of the BPCA. This means that all the Departments EHA's are now holders of that qualification.

While the Department continues to offer a pest control service to private householders, the sale of rodenticide to the public was discontinued for a time. This was due to the fact that it was considered that the labelling of such rodenticides was inadequate to warn the public of the possible danger involved in handling such products. Suitable labels were obtained, and now all rodenticide sold to the public carries all the necessary information and warnings.

TABLE XIV — 6

Pest control

	1987	1988	1989
Disinfestation visits (Fleas, bed bugs, flies, etc.)	88	83	61
Rooms treated in above visits	470	412	418
Rodent Control visit (new)	143	181	210
Rodent control visits (re-visits and monitoring)	—	183	237

The use of a more effective insecticide and better equipment is reflected in the decline in visits to disinfest for fleas, bed bugs, etc.

The increase in rodent activity is consistent with the mild winters and dry summer during 1988 and 1989. Rat infestations have been reported from open areas of land and also from beaches. It is unusual for rats to be active during daylight hours, and they tend to keep away from human presence, but complaints have been received of rats scavenging near humans in broad daylight.

All complaints regarding commercial premises are referred for private contractors treatment, as are all States properties, otherwise the overall figures for 1989 would have been considerably higher.

LEGISLATION

The shortcomings in our legal powers is being addressed albeit slowly and we are hopeful of updated and new legislation being accepted which will give the officers the necessary legal backing to perform their duties.

ENVIRONMENTAL HEALTH EDUCATION

The section continued to offer courses in Basic Food Hygiene running in conjunction with the Institute of Environmental Health Officers. Several successful courses have been held. Environmental Health Officers participated in lectures for both the Basic Food Hygiene Certificate and the Intermediate Food Hygiene Certificate at Highlands College. Steps are being taken to improve the facility for translation of these courses into foreign languages, particularly Portuguese.

Health education is becoming increasingly important and must ensure that the emphasis on "prevention rather than cure" is promoted and maintained. Preventive action will eventually lead to a reduction in risk factors and a reduction in cases of illness.

CONCLUSIONS

The services that the Environmental Health Section has been able to provide in 1989 have to some extent been affected by the availability of resources. It is hoped that the resources of the Environmental Health Section, both financial and staffing, will in future more readily match the needs of a good Environmental Health Service.

XV

Health Promotion/Education

The Health Promotion/Education Unit at Cyril Le Marquand House continues to act as an invaluable resource for all groups in the community concerned with the dissemination of information on health related topics. Pamphlets and booklets are readily available at no cost and an extensive library of audio and visual aids, training packs, reference texts are also available on loan. This Alladin's cave of aids to health education has been assiduously developed during the past decade. In addition to these extensive resources, Miss Sheila Squibb is available to give advice, support and help to plan, develop and maintain programmes or campaigns in the field of health education and promotion.

Ante-Natal and Young Children

The Unit supports the health education activities of health visitors and midwives who organise and run parent craft courses for young mothers and for couples expecting a new baby. Well produced videos on pregnancy, birth and baby care contribute to much valued anti-natal classes.

Schools

Following in-service training in 1988 with a group of teachers from primary schools, the "Health for Life" programme from the Health Education Authority, has been introduced in a limited number of primary schools. This exciting health education package for younger children focuses on how the body works, keeping safe, personal relationships, health eating, the world of drugs and exercise and rest. An in-service course on "Sex Education in the Primary School" was organised in conjunction with Mr. D. Gibaut.

At secondary school level, two workshops on "The Controversial Issues in Health Education in Secondary Schools" were offered and well attended. The issues concerned included AIDS, drugs, alcohol and sex education. Contributors include staff from the education and youth service, the drugs squad as well as a person who has had close personal contact with an AIDS victim. In addition, resource materials and information are regularly provided to secondary schools on request and Miss Squibb acts on a consultancy basis to help schools make appropriate choices of health promotional materials. The Unit also contributed to the Channel Islands Youth Services annual weekend training conference.

Alcohol and Drugs

During 1989 the problems related to alcohol and drugs misuse in the community remained one of considerable public concern. Regular opportunities occured for public education on the key issues involved through articles in the J.E.P. and with interviews on Radio Jersey and Channel T.V. The media remain an invaluable support to public education on these matters.

Alcohol education and training programmes were mounted for nurses and other primary care workers. Youth workers, health visitors, probation staff and child care staff participated in training programmes aimed at increasing their knowledge and skills in dealing with alcohol and drug problems and in educating others about these problems. It is acknowledged that specialist workers will only deal with a minority of problem drinkers and drug abusers, therefore the continued education of a multitude of others is essential. The "Drinking Choices" training programme was organised jointly with the Health Promotion Unit with ten Jersey representatives in attendance.

Smoking

The Health Promotion/Education Unit recognise that smoking is the single largest contributor to ill health and premature death in the community. Sustained efforts were made during the year to encourage No Smoking policies in a range of locations. Smoking policies in the workplace will continue to be a major concern of the Unit. Appropriate materials and advice with regard to such action are available from the Unit. National No Smoking Day in March attracted considerable media attention. Data from national and local surveys (Household Expenditure Survey) published in 1989 revealed a disturbing level of cigarette smoking amongst young women aged 15 to 25 years. This group will be a particular target for health education here and in the U.K. in 1990.

Aids

The frantic activity of 1987-88 in the field of AIDS and HIV awareness slowed up in 1989. Materials on these topics remain in demand and the Unit contributed to a number of workshops and meetings throughout the year. However, the impetus to public education was less marked in 1989. The Unit did, however, participate in a well-publicised launch of a new educational initiative (Drawing the Line) aimed at young people. This was well attended by young people from schools and youth clubs.

Look After Yourself

In 1989 Miss Squibb and Mr. Lakeman (Education Department) completed their training as Look After Yourself tutors. This project introduces participants to a comprehensive look at their own health and fitness. Weight control, diet, general fitness, managing stress, drinking sensibly and smoking are issues dealt with in the programme. Both tutors organised and ran L.A.Y. courses in 1989. This programme will be extended in 1990 as part of a lifestyle advisory service.

Miscellaneous

The Unit contributes a monthly topic on health promotion of current interest on Radio Jersey. Miss Squibb is a member of the Road Safety Panel and was part of a working group who produced a good quality video on "Road Safety for the Elderly". She also participated with a group charged with the task of producing guidelines for staff and carers of people with learning difficulties (mental handicap) on the subject of personal relationships and sexuality. Contributions from the Unit are regularly requested from the School of Nursing as part of their continuing nurse education. In 1989 such assistance was provided to courses on nursing the elderly and psychiatric nursing.

In the autumn of 1989 the Public Health Committee confirmed its commitment to an extended role for health promotion with the appointment of a director to the service. A second health promotion/education officer will be appointed in the first half of 1990.

XVI

Communicable diseases

The Department investigated a number of outbreaks of food poisoning during the year. Salmonellae were detected in 266 cases and a further 10 unspecified cases were investigated. Five notified cases of shigellosis were investigated. More detail of some of the outbreaks appear in the Environmental Health section of this report.

There were 6 cases of infective hepatitis notified during the year.

Twelve cases of glandular fever were notified last year, three more than in 1988 but clearly this low number in no way represents the true frequency of this infection in the Island. Three cases of scarlet fever were notified.

There were 107 cases of measles reported during 1989 and this is a considerable increase over the past two years — only 3 cases were reported in 1987 and 12 cases in 1988.

In 1989 — seven cases of whooping cough were notified this is an increase of seven on the previous year as there were no cases reported in 1988.

TABLE XVI — 1

Communicable diseases (other than tuberculosis) notified in 1989

International code	Disease	Notifications
003	Salmonella infections (other than typhoid and paratyphoid)	266
004	Shigellosis	5
005	Other food poisoning, unspecified	10
033	Whooping cough	7
034	Scarlet fever	3
055	Measles	107
070	Infective hepatitis	6
075	Glandular fever	12
084	Malaria	1

Tuberculosis

Pulmonary tuberculosis is still an important health hazard with eight cases having been diagnosed in the Island during 1989. All 8 cases were sputum positive.

The eight cases notified in 1989 (seven males and one female) were all indigenous cases.

In addition one case (male) of non-pulmonary tuberculosis was notified in 1989 being a recent arrival in the Island from abroad.

None of the cases had received B.C.G. previously.

When the index case is sputum smear-positive, close contacts are asked to attend for a chest x-ray and, if under 40, given a tuberculin test. If the tuberculin test is negative, B.C.G. vaccination is offered. If the x-ray is negative, repeat x-rays are arranged after 6 months, 12 months and 2 years. If a contact is aged under 15 years and tuberculin positive, chemoprophylaxis is considered. Casual contacts are asked to attend for one chest x-ray only.

When the index case is smear negative, culture positive or culture negative or non-pulmonary, both close and casual contacts are asked to attend for one chest x-ray only.

TABLE XVI — 2

Communicable Diseases — Tuberculosis cases notified in 1989

Type	Males	Females	Totals
Pulmonary	7	1	8
Non-pulmonary	1	—	1
Totals	8	1	9

THE SPECIAL CLINIC

I am indebted to Mr. Roger Mitchell, Consultant Genito-urinary Surgeon, for this report on the Special Clinic:

At first sight, the further decline in total attendance at the Clinic appears encouraging. A total of 1,110 patients were seen compared with 1,335 in 1988. In fact, after a peak in 1985 the figures are now comparable with 1972.

It would be tempting to assume that this is due to greater awareness of the risks of promiscuity as a result of the AIDS campaign and the undoubted increase in the use of condoms as a safety barrier. Other centres are reporting a fall in numbers and these factors must be playing a part. An encouraging development is that the U.K. Department of Health has recently announced that the projected calculation of young people dying from AIDS in the next few years has been drastically revised downwards.

However, a detailed analysis of the local figures gives reason for concern. Accepting that at the moment HIV infection is not a great problem in Jersey one would assume that if education and sexual awareness were playing a part, then other sexually transmitted diseases would be falling. This is not the case. The incidence of Gonorrhoea has gone up from 21 cases in 1988 to 28 in 1989. Chlamydia and non-specific urethritis, previously lumped togther in 1988 when 33 cases were seen, now in 1989 stands at 55.

Further research reveals that we have never taken into account the number of cases seen by general practitioners. By using the Pathology Laboratory computer I have been able to work out the crude figures for the last six months of 1989. In this time, eight cases of Gonorrhoea were found in the Special Clinic, and five by GPs. Similarly, 17 cases of Chlamydia were found in the Special Clinic and 28 by the GPs. We are therefore deluding ourselves by confining our attention to the Special Clinic as an indication of the prevalence of sexually transmitted diseases in the Island.

Finally, the seasonal incidence of attendance is worthy of consideration. In August the figures increase. Throughout the whole year only 2% of patients are Jersey born — perhaps most Jersey patients seek treatment from their own doctor. The other 98%, who usually do not have their own general practitioner, seek advice at the Clinic. It is because of these itinerant patients that we must exercise constant vigilance in sexual education locally. When (not 'if') heterosexual HIV becomes a problem then it will certainly be transferred to the resident Island population.

TABLE XVI — 3

Comparison of Total Attendances 1984—1989

1984	1985	1986	1987	1988	1989
1,700	*2,112	1,973	1,737	1,335	1,110

*Peak attendances

TABLE XVI — 4

Number of attendances by sex, new and old cases and month of attendance 1989

	Males			Females			Both sexes		
	New	Old	Total	New	Old	Total	New	Old	Total
January	6	39	45	2	10	12	8	49	57
February	7	43	50	4	5	9	11	48	59
March	14	45	59	6	20	26	20	65	85
April	13	54	67	10	29	39	23	83	106
May	14	55	59	12	35	47	26	90	116
June	19	59	78	7	24	31	26	83	109
July	19	45	64	6	20	26	25	65	90
August	24	70	94	11	42	53	35	112	147
September	14	57	71	5	12	17	19	69	88
October	13	51	64	4	12	16	17	63	80
November	10	65	75	8	22	30	18	87	105
December	10	41	51	3	14	17	13	55	68
Totals	163	624	787	78	245	323	241	869	1,110

TABLE XVI — 5

New conditions classified by disease, age and sex — 1989

	Under 20 years		20 – 24 years		25 years and over		Totals All ages		Totals (both sexes)
	M	F	M	F	M	F	M	F	
Late treated syphilis	—	—	—	—	1	—	1	—	1
*Gonorrhoea	—	—	14	3	10	1	24	4	28
*Chlamydia	3	3	15	8	8	2	26	13	39
*Non-specific urethritis	—	—	6	—	10	—	16	—	16
Trichomonas	—	—	—	1	—	2	—	3	3
Gardneralla	—	—	—	1	—	—	—	1	1
Other causes/balanitis	—	—	4	—	2	—	6	—	6
Candida	2	5	5	10	4	5	11	20	31
Pediculosis	—	1	16	4	3	—	19	5	24
Primary herpes	1	—	3	1	2	—	6	1	7
Recurrent herpes	—	—	3	1	6	1	9	2	11
Warts	3	5	17	12	9	2	29	19	48
Recurrent warts	—	2	3	3	4	1	7	6	13
Antigen +ve Hepatitis B	—	—	—	—	1	—	1	—	1
Other conditions treated	—	—	6	3	8	1	14	4	18
*No infection found	1	—	18	13	22	13	41	26	67
Referred elsewhere	—	1	—	3	2	1	2	5	7
Grand totals (**all conditions)							212	110	322

*Significant increase over 1988

**One patient may have serveral conditions at the same time

TABLE XVI — 6

CHLAMYDIA 'ELISA' TESTS

1st July, 1989 to 31st December, 1989

	POSITIVE		NEGATIVE	
	Male	Female	Male	Female
Special Clinic	12	5	63	38
From GPs and others	7	21	67	303
Totals	19	26	130	341

Of the 118 specimens received from the special clinic 17 (14%) were found positive.

Of the 398 specimens from other sources 28 (7%) were found positive.

TABLE XVI — 7

HERPES SIMPLEX SWABS FOR CULTURE

1st July, 1989 to 31st December, 1989

	POSITIVE		NEGATIVE	
	Male	Female	Male	Female
Special Clinic	2	—	3	—
From GPs and others	5	17	23	82
Totals	7	17	26	82

TABLE XVI — 8

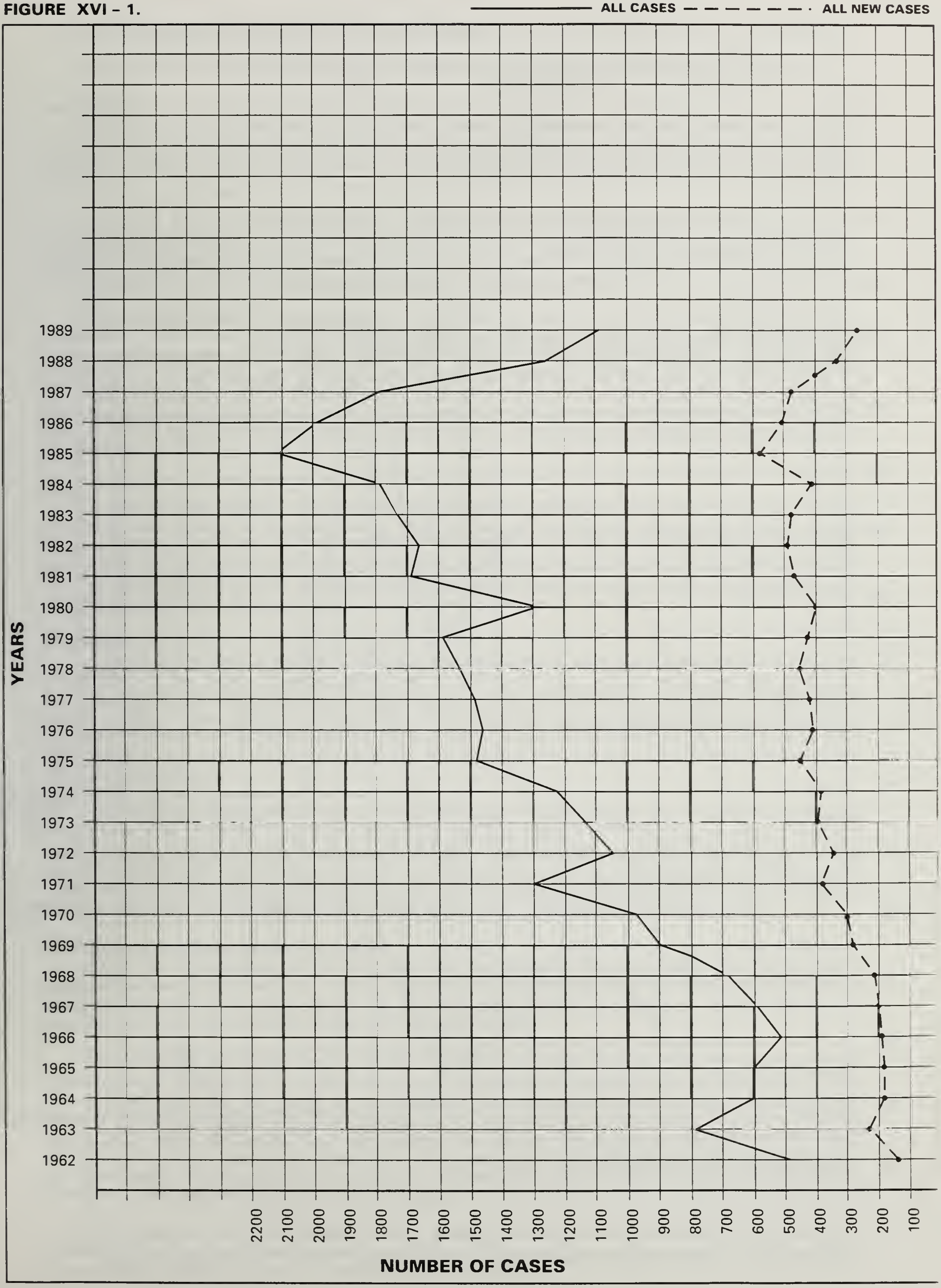
GONORRHOEA TESTS

1st July, 1989 to 31st December, 1989

	TESTS	POSITIVE RESULTS
Special Clinic	65	8
From GPs and others	88	5
Totals	153	13

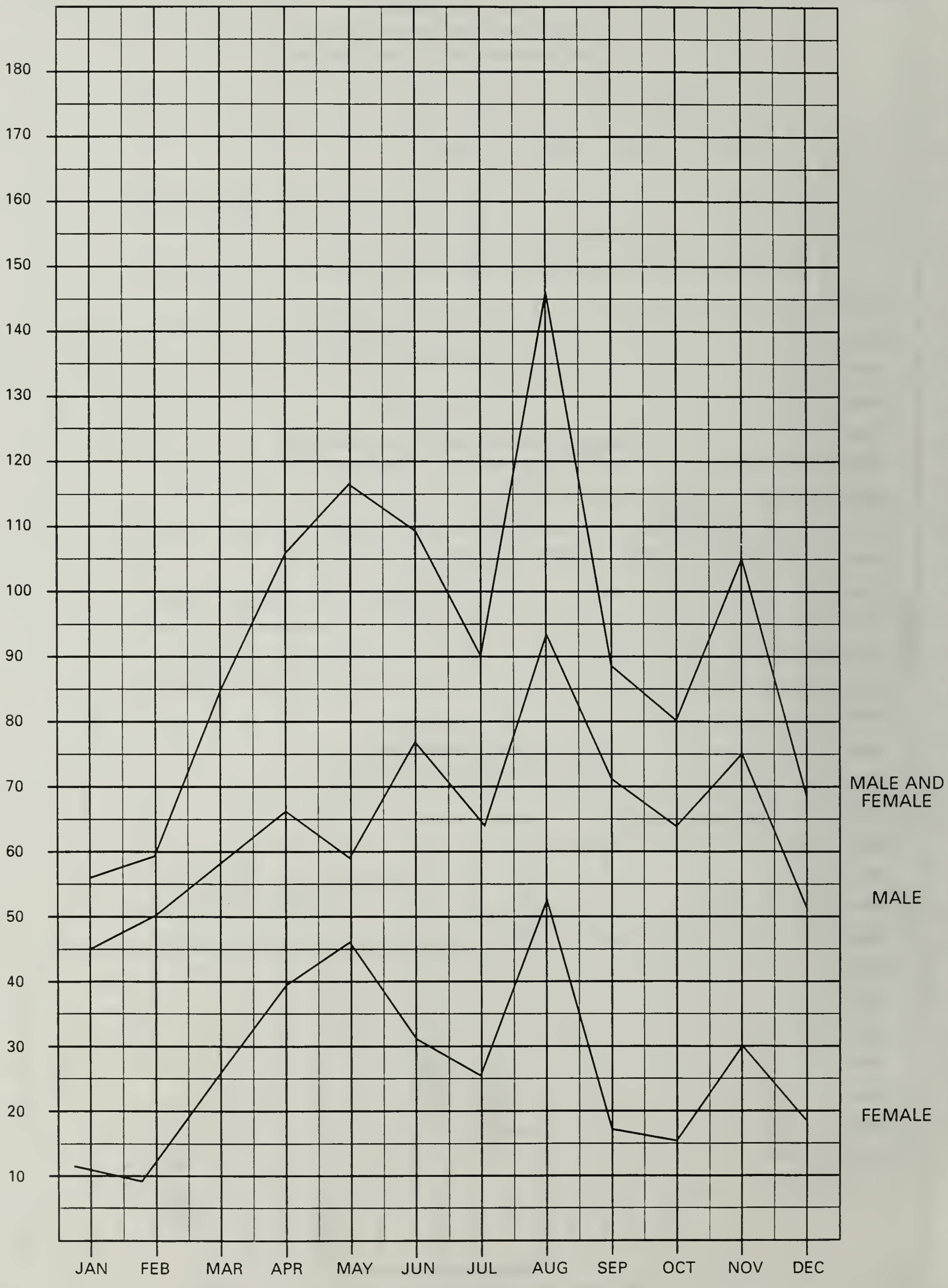
SPECIAL CLINIC 1962 - 1989

FIGURE XVI - 1.



SPECIAL CLINIC 1989
ATTENDANCE BY MONTH
TOTAL 1,110

FIGURE XVI – 2



ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

I am indebted to Mr. Albert Andrews, AIDS Counsellor and Co-ordinator, for this report:

Introduction

At the end of the first decade of AIDS with some 178,000 cases worldwide, both the size and shape of the epidemic are beginning to come into focus. AIDS is now recognised as one of the major infectious disease epidemics of the century and as the primary public health problem of the post-war era.

Although homosexual men make up some two thirds of the Western epidemic it is becoming clear that the rapid spread in this group is over, and that homosexual men are not the main avenue of entry for Human Immunodeficiency Virus (HIV) into the rest of the population. Attention has thus increasingly shifted to the HIV problem in intravenous drug misusers.

Given that AIDS is already present to at least a limited extent in the heterosexual population of all Western countries, what is the liklihood of epidemic hetersexual AIDS? Other sexually transmitted diseases of homosexual men, such as Hepatitis B, have not become epidemic in the general population — suggesting that the sexual ecology of heterosexual society in general will not sustain the rapid expansion of HIV infection that took place in homosexuals. On the other hand the persistence of retroviral infection and the likelihood that HIV carriers are infectious for much of the latency period suggest that there may be a slow build-up of a reservoir amongst the sexually active population.

Care

A total of nine patients with opportunist infections associated with their acquired immune deficiency were treated in hospital during 1989. As part of the planned programme of care, and in keeping with agreed policy and the wishes of the patient, their stay in hospital was brief. All were discharged into the community where treatment and support was provided by the Family Nursing Service, general practitioners, voluntary and other caring agencies as necessary. One person who was infected with HIV died.

Education

A three-day workshop was held in March, the objectives of which were to provide a good base knowledge of the clinical, psychological and social issues surrounding AIDS and HIV infection. Representations from a wide range of local organisations attended and included the Samaritans, Jersey Hospice Care, Family Nursing Services, Christian Care for AIDS Sufferers Associaiton, Probation Service, Home Helps Society, Public Health, Jersey AIDS Relief Group and nursing staff from various specialties within the hospital. The number was limited to 20 and all attended the follow-up day in June.

The educational effort directed at groups involved in health care in the community continued throughout 1989. Alison Cabot, the Virologist at the Department of Pathology, and Jane Averty, a health visitor, held four training courses of 16 weeks total duration, targeted at community-based health care professionals. Additionally, at the request of the Children's Department, they provided three similar training courses for child-minders and clients of New Ways Family Centre. Nine sessions of tuition on HIV infection were also provided for the School of Nursing.

Lead Role of the Public Health Committee

Since the introduction of HIV infection into the Island in the mid 1980's the Public Health Committee has taken a lead role in the prevention of the disease, and the care and treatment of patients. The manner in which the caring services have adapted to caring for these patients is a success story and one of which Jersey can be justly proud.

However, it is recognised that in the field of health education against AIDS the message is not reaching those most at risk. In order that a more comprehensive programme be established in this area a direct approach was made to the Education Committee by the Public Health Committee to discuss a shared responsibility. This resulted in the formation of a new Health Education Strategy Group with responsibility for policy and strategic guidelines. The Group is supported by a Clinical Co-ordinating Team, mainly composed of persons responsible for care and treatment of AIDS and HIV infection in the hospital and community; a Communications Team, on which the media are represented and the Health Promotion Unit. (See Table XVI - 9)

It is essential that the medico centric view of HIV infection and AIDS, which gives the impression that vaccines and medical treatment are the only solution to the problem, is discouraged. The emphasis must be placed on prevention of HIV infection.

Counselling

Counselling is the most common and useful approach to the psychological manifestations of HIV disease. This should be provided prior to HIV antibody testing to reduce unnecessary fears, provide information, promote those behaviour changes needed in order to reduce the risk of infection and to screen for those persons seeking testing but who are unprepared for a possible positive result. Counselling represents the first line therapeutic approach for those with mild to moderate anxiety and depressive states found in HIV antibody-positive persons, and should be offered to partners and family members to avoid a breakdown in relationships at such a critical time for the patient.

The Hospital Counselling Group continue to see people referred to them by hospital physicians, general practitioners and by direct enquiry through the Freephone (1200 222). The number of clients seen by the Group in 1989 was 68. This represents a decrease of 24 over the previous year and probably reflects the low key approach by both the U.K. government and the Public Health Committee.

Change in Definition of AIDS

The definition of AIDS has altered as the natural history of the virus has become clearer. In 1981 the Centre for Disease Control in Atlanta produced a scheme based on opportunistic infections and other conditions associated with impaired cell mediated immunity. When serological testing became available the case definition was modified to include other diseases if antibodies to HIV were also present. A case of AIDS is defined as an illness characterised by one or more indicator diseases, depending on the status of laboratory evidence of HIV infection. The list of indicator diseases is extensive and includes conditions such as oesophgageal candidiasis, extrapulmonary cryptococcosis and Karposi's sarcoma. It should be noted that patients previously classified as AIDS Related Complex (ARC) and AIDS are now included in one category — CDC4.

Laboratory Testing

A total of 4,464 tests for HIV antibodies were performed by the Pathology Laboratory in 1989. Table II shows the proportion of blood donor to non-donor tests. The number of clinical requests for HIV antibody tests fell from 532 in 1988 to 418 in 1989. As in the previous year NO antibody positive results were detected in the blood donor population. Two new confirmed cases were found in the non-donor tests, which brings to 19 the total number of HIV antibody positive tests reported to the Disease Surveillance Centre in London since testing began in Jersey.

The Future

During the past year substantial progress in the clinical care of people with AIDS and HIV infection has been accomplished. This progress has been based on a fuller understanding of viral and host biology, the fruition of epidemiological studies of natural history and disease spectrum and results of important clinical trials, as well as worldwide organisational and policy advances. Added to these has been the continuing hard work and dedication of health care professionals involved in clinical care and also in clinical research.

A sense of cautious optimism for those who have HIV-related illness is warranted because of the development of effective therapy which, at the very least, prolongs and improves the quality of life. For those infected with HIV who are without clinical illness, preventive strategies which may prolong good health have begun to emerge as well. However, these positive aspects must be seen against a background of an increasingly large population of sick and dying young men, women and children. Quite apart from the human toll, this imposes a growing drain on the clinical health-care resources available to provide the fruits of these advances to those in need.

TABLE XVI – 9

REVISED HEALTH EDUCATION / AIDS ADVISORY STRUCTURE

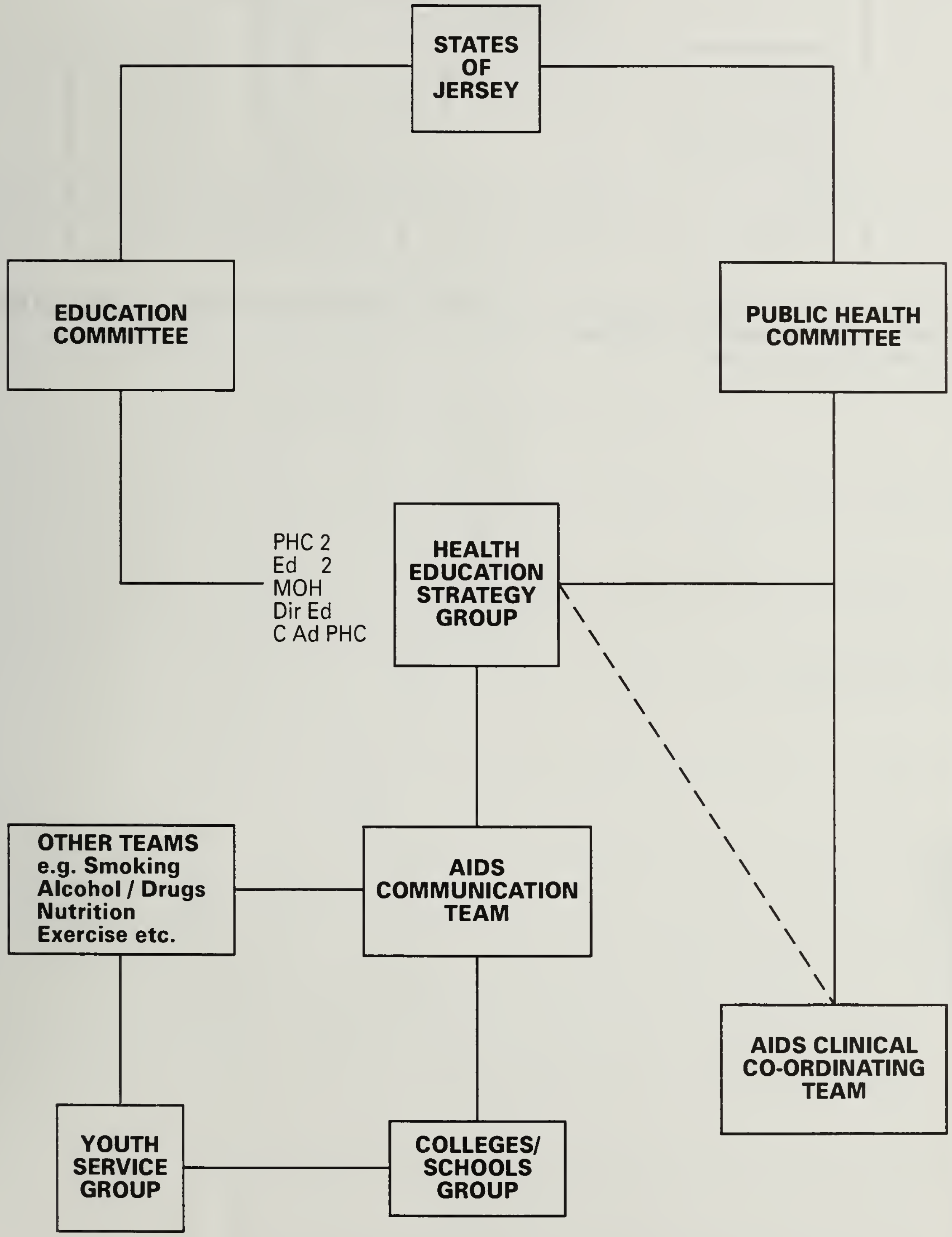


TABLE XVI — 10

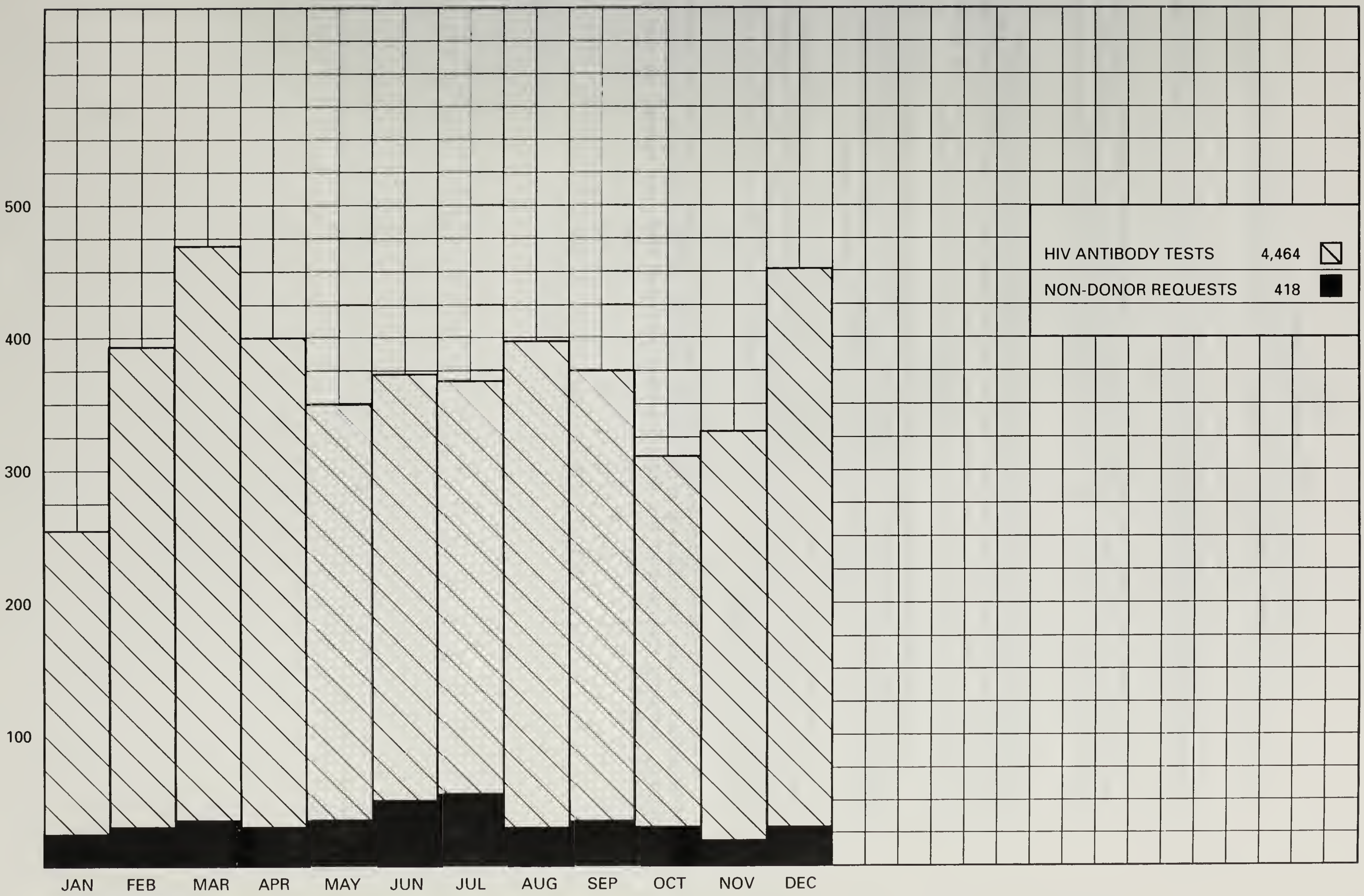
Transmission Group	Disease State			Total
	Not Known	Asymptomatic	*CDC 4	
Homosexuals	3	—	4	7
I.V.D.A.**	2	4	1	7
Heterosexuals	1	—	1	2
Haemophiliacs	—	—	1	1
Other	1	—	1	2
Totals	7	4	8	19

*It should be noted that patients previously classified as AIDS Related Complex (ARC) and AIDS are now included in one category — CDC4.

**Intravenous Drug Abusers.

FIGURE XVI – 3

PROPORTION OF TOTAL HIV ANTIBODY TESTS WHICH ARE NON-DONOR DURING 1989



XVII
Welfare of the Aged

I am indebted to Mrs. Annette Lowe, Senior Social Worker, for this report on the welfare of the aged:

A new post will be created for a social worker to become part of the multi-disciplinary team working with the elderly patients and with the Rehabilitation Unit at Overdale. It is hoped that early in 1990 an appointment will be made.

The number of referrals to the Department dropped slightly to 308 in 1989, 58 of these being in the younger age group, and the number of people placed in Care directly through the Department also decreased to just under 100 — 74 to Residential Homes and the others to long-stay hospital units.

One of the reasons for the apparent decrease in the number of people being placed in Care may well have been the development of the two Care Assistant schemes — one based with the Family Nursing Services and run by Mrs. Margaret Foulds, and the other with the service for the Elderly Mentally Infirm. Although both these schemes are in their formative stages, they are already promoting the Publich Health Committee's aim of keeping people in their own homes.

During the year Mrs. Lowe attended a three-day course in Birmingham on the Registration and Inspection of Rest and Nursing Homes, and also spent a week with the Hammersmith and Fulham Social Services Department, working with the senior social worker responsible for HIV and AIDS. In October Mrs. Keenan attended the NAIDEX Exhibition of aids for disabled people.

In November Mrs. Lowe gave a talk on the work of the Department to the first ENB course on Nursing Elderly People, and in December she spoke on AIDS and the Care of the Child at a seminar organised by Highlands College. She is also a member of the Working Party on Charges, which is reviewing the charging procedure for all long-stay accommodation for which the Public Health Committee are responsible.

In April the Residential Homes Sub-Committee once again organised a party for the residents of Residential Homes. This was held at the Atlantic Hotel and was attended by 76 guests and 23 helpers, including members of the Sub-Committee and staff from the Homes, as well as Departmental staff.

TABLE XVII — 1

Persons placed in private old persons' homes by the Public Health Committee 1989

	Males	Females	Totals
Persons boarded out 1st Jan. 1989	36	134	170
Persons added during year	10	39	49
Persons removed/died during year	15	42	57
Persons remaining 31st Dec. 1989	31	131	162

The above figures relate to individuals chargeable to Parishes and, in the case of non-natives, to the Public Health Committee.

TABLE XVII — 2

Persons placed in old persons' homes by the Public Health Committee 1981 – 1989

Year	Males	Females	Totals
1981	31	104	135
1982	24	112	136
1983	30	120	150
1984	31	123	154
1985	28	126	154
1986	29	129	158
1987	43	143	186
1988	49	172	221
1989	46	173	219

RESIDENTIAL HOMES FOR THE ELDERLY AND NURSING HOMES

I am indebted to Mrs. Anne Le Feuvre, Nursing Advisor to the Residential Homes Sub-Committee, for this report:

During 1989 one residential home closed and two new homes opened. All homes were visited at least once and some of them several times. Much time is spent investigating complaints.

Many of the homes are efficiently run by caring staff, and the residents seem happy and content. Of the remainder there are various problems, some of which occur over and over again.

Some of the main problems during 1989 were:

a. Overcrowding, leading to
b. lack of privacy and
c. lack of storage space.
d. Damage and unsafe furniture.
e. Poor quality food.
f. Lack of stimulation and motivation.
g. Irregularities over pocket money.
h. Quality of staff, rapid turnover of staff and complaints re staff.
i. A partnership dispute.

Suggested improvements have included:

1. An increase in staff/resident ratio, including night staff.
2. Attention to the quality and quantity of food; menus displayed for residents and made out a few weeks in advance, with a hot alternative offered if not suitable for individuals. Evening meal not served before 17.30 hours.
3. Flexibility in times of rising and going to bed.
4. Improvements in furniture, decor and facilities for the infirm.
5. Accommodating room-bound residents nearer to dayrooms and staff.
6. Ensuring that call-bells in rooms, toilets and bathrooms are within reach of residents.
7. Improved safety in storage and administration of drugs.
8. Display of staff rotas, which should be kept for inspection.
9. Keeping fire doors clear at all times.
10. Providing smoking areas for staff.
11. Notifying the Medical Officer of Health if the matron/owner is absent from the home for one month or more.

Most of the homes welcome visits, but there are the few who object and make this obvious.

A seminar (open afternoon) on various aspects of caring for the elderly was held at the Jeanne Jugan Residence on November 1st. Approximately 70 staff from residential homes attended and the feedback was most encouraging.

XVIII
Le Geyt Adult Training Centre

I am indebted to Mr. Derek Hart, Manager of Le Geyt Adult Training Centre, for this report:

ADMISSIONS ETC.

Three people transferred from Mont à l'Abbé School, two male and one female. One young man returned to the Centre after attending Rural Enterprises for a short while. A young woman moved to the Centre from the Pinewood unit at Highlands College. One woman came to us on a part-time basis — she had not recently attended education or day care facilities. One man returned to the Centre after an absence of several years, he had left to help his aged mother.

Two people retired — a woman chose to remain on her ward at St. Saviour's Hospital and a man now lives at Gardner Home.

One man left to take up a part-time job in the Market. One man gained part-time employment at Fort Regent and another had part-time seasonal work with a beach concession.

The movement of people in and out of the Centre was not as great in 1989 as in previous years. We were disappointed that the opening of Rural Enterprises did not have the effect on Le Geyt attendances that was anticipated, we had hoped that at least six people would have moved.

The lack of alternative provision has very serious consequences for Le Geyt Centre and for the people who use its services. Le Geyt cannot continue to provide for the diverse needs of all adults with a mental handicap.

TABLE XVIII — 1

The total number of people using Le Geyt Centre at the end of 1989

	Male	Female	Total
Special Care Services	7	1	8
Pre-retirement	2	6	8
Main Centre	36	49	85
Totals	45	56	101

WORK

Great efforts were made to find work for those attending the Centre. In the Centre we recognised areas of existing strengths and have tried to support and encourage their development. Both the printing department and gardens have increased their activities. However, work for those with special needs, and indeed those using the special care service presented particular problems.

A staff member took on the special responsibility for work seeking. He visited local industry, placed adverts in the local press and appealed on local radio, but work is still in short supply. This situation is forcing us to look at our own potential for manufacturing and several ideas are being explored.

THE ELDERLY

A pre-retirement group was planned to cater for the needs of those older people still attending Le Geyt Centre. Mrs. Kelly took on the task of establishing a separate provision for those people over the age of 60, her prime objective being to find community-based provision for each individual within the group. Thanks to the support of the Community Health Care Team, the Good Companions' Clubs and many other groups and individuals, a place was found for all those who needed placement.

Two of the original group decided to retire from the Centre at the close of the year and we now have six people over the age of 60, each attending an alternative provision on at least two sessions per week.

Our aim is to offer a pre-retirement service to each person as they approach the age of 60. Having been helped to find a suitable alternative they would retire from the Centre at 60 years of age. The service uses existing normal provision within the community. The support and encouragement given by those involved in providing services to the elderly in Jersey is impressive.

Le Geyt is at the forefront in integrating older people with a mental handicap into community provision.

DIRECTIONAL SUPPORT

This is a new development within the Centre and involves one member of Centre staff. Working closely with the Education Department we aim to offer those using the service:

a. A smooth transition into the Centre either from school, Highlands College or the community.

b. Assessment for interests as well as for competence and ability.

c. The monitoring of movement of people within areas of work and helping them fit in, ensuring that they have basic skills.

d. Development of individual training programmes.

FURTHER EDUCATION INVOLVEMENT

We have the continued support and involvement of the lecturers from Highlands College. They offer a range of opportunities previously denied to people with a mental handicap. We welcome Pat Sturman to the teaching staff and hope that he enjoys the new challenge of working at the Centre.

All Centre staff are sad and sorry to say goodbye to Sue Huelin who leaves at the end of the year. She contributed a great deal to the Centre in general, and the special care service in particular.

LE GEYT CENTRE FIVE-YEAR PLAN

During the year a great deal of work went into the preparation of a five-year plan for Le Geyt Centre. The proposals were widely discussed and the final plan will be presented to the Public Health Committee for approval in 1990.

TRAINING AND COURSES

I was fortunate in attending a management course held in Bournemouth which comprised one week in July and one week in September. The course was led by tutors from Portsmouth Polytechnic and proved to be a most beneficial and worthwhile experience.

Mrs. Kelly attended a short management course at Highlands Management Centre.

Four Instructors participated in the Open University course Mental Handicap — Patterns for Living. In addition there were regular staff development meetings.

LE GEYT CENTRE TRAINEES SUPPORT GROUP

A small group of parents and friends have supported the Centre over the past year. Their fund-raising efforts have been particularly appreciated.

RIDING FOR THE DISABLED

This voluntary organisation has provided a worthwhile service over a very long period of time. We unfortunately had to cancel several sessions during the year. This was regretted but unavoidable.

LE GEYT CENTRE PREMISES

Despite some remedial work the Centre is still in need of repair and redecoration.

CONCLUSION

During 1989 the Education Committee made several radical changes in its approach to people with learning difficulties. A full report was commissioned from the Head of the special school, who was given one term in which to look at the needs of this group. She was appointed as adviser and several initiatives were consequently launched to provide support and opportunities to people with learning difficulties.

All this has raised expectations — Le Geyt must adapt to meet these expectations.

TABLE XVIII — 2

Number of trainees at December 1989 by age and sex

Age group	Male	Female	Totals
Under 19	2	1	3
20 – 29	15	19	34
30 – 39	7	12	19
40 – 49	7	9	16
50 – 59	5	8	13
Totals	36	49	85

Special Care

Age group	Male	Female	Totals
Under 19	—	—	—
20 – 29	7	1	8
Totals	7	1	8

Pre-retirement

Age group	Male	Female	Totals
60 and over	2	6	8
Totals	2	6	8

The total number of trainees attending the Centre is 45 Males and 56 Females (101 in total).

TABLE XVIII — 3

Number of trainees classified according to causative or associated handicaps by age and sex groups

Causative or associated handicaps	Under 19		20 – 29		30 – 39		40 – 49		50 – 59		Over 60		Totals
	M	F	M	F	M	F	M	F	M	F	M	F	
Epilepsy	—	—	6	2	1	3	1	2	—	2	—	1	18
Spastic diplegia	—	—	4	1	—	1	—	—	—	3	—	—	9
Downs syndrome	2	—	4	6	2	2	—	2	—	2	—	—	20
Hypothyroidism	—	—	—	—	—	1	—	—	—	—	—	—	1
Microcephaly	—	—	—	—	—	—	—	—	—	—	—	1	1
Hydrocephaly	—	—	1	—	—	—	—	—	—	—	—	—	1
Spina Bifida	—	—	1	—	—	—	—	—	—	—	—	—	1
Post-meningitic	—	—	1	—	1	—	—	—	—	—	—	—	2
Tuberous Sclerosis	—	—	—	—	—	—	—	—	—	—	—	—	—
Accidental brain damage	—	—	—	—	—	—	—	—	—	—	—	—	—
Cockaynes syndrome	—	—	1	—	—	—	—	—	—	—	—	—	1
Hearing impaired	—	—	1	3	—	1	—	1	1	—	—	—	7
Visually impaired	—	—	—	1	—	—	—	—	—	—	—	—	1
Psychiatric disorder	—	—	—	—	—	—	1	1	—	—	—	—	2
Prader-Willi syndrome	—	—	—	1	—	—	—	—	—	—	—	—	1
Cri du Chat syndrome	—	—	—	1	—	—	—	—	—	—	—	—	1
Totals	2	—	19	15	4	8	2	6	1	7	—	2	66

XIX
Crematorium

I am indebted to Mr. Roy Edlin, Crematorium Superintendent, for this report:

The total number of cremations carried out during 1989 was 461, an increase of 15 on 1988. Included in this figure are six Jersey residents and one non-resident who died away from the Island, and 11 visitors. 53 Roman Catholics were cremated, a decrease of 15 on 1988. A total of 10,012 cremations have now taken place since the crematorium was opened on 19th December, 1961. The average age of those cremated was 68 years, as opposed to 65 years in 1988.

As usual, four Memorial services were held during the year: on Easter Sunday, the last Sundays in June and September and the Sunday before Christmas Day. Reverend J. N. Hollis, Rector of St. Saviour, took the Easter service with Mr. A. G. Picot playing the organ; Reverend G. Baker from Jersey Hospice Care took the services in June and September, with Mr. O. Le Breton and Mr. A. G. Picot playing the organ, and the Christmas service was conducted by Reverend W. Hall from St. Mark's Church, with Mr. D. Querée playing the organ. We are, as always, most grateful to the organists for giving their services free on these occasions. All four services were well attended, with relatives bringing many pot plants to enhance the floral decorations in the Chapel and foyer.

The traditional wreath-laying ceremony took place on Liberation Day, 9th May, at the Memorial to the slave-workers who died in Jersey during the German occupation. This event was well attended and the weather was warm and sunny, allowing many to renew old acquaintances.

During the year there were 180 placings of ashes in new plots in the rose gardens, and 108 in re-opened plots. The remaining 173 sets of ashes were taken away by Funeral Directors for disposal. In addition, the ashes of one resident who died away from the Island were placed in a new plot; those of another in a re-opened plot; those of three non-residents in new plots and those of 11 non-residents in re-opened plots.

Book of Remembrance entries totalled 231 with 54 memorial cards and 10 miniature books being purchased.

The organ was very well used, being played at 260 of the 335 services which were held entirely in the Crematorium, and was maintained to its usual high standard by Mr. Reg Lane, of builders Hill, Norman and Beard. Two general view photographs of the crematorium and grounds were available through Mr. R. Querée and have proved to be popular with those attending the Crematorium, particularly during the winter months when there are no roses on show. During the very dry summer, the opportunity was taken to remove a further section of the original roadway from under the lawn and construct two new rosebeds which should, together with those previously made, give sufficient space for ashes for many years to come.

A greatly admired new blue carpet was laid throughout the Chapel, foyer, ministers' room and office. At the same time the original fixed kneelers were replaced with individual ones which are now hung in the pews, making cleaning much easier.

In September, the Superintendent attended the combined conference of the Institute of Burial and Cremation Administration, of which he is an associate member, and the Federation of British Cremation Authorities, of which the States of Jersey Crematorium is a member. In 1989, the venue for this excellent and well attended conference was at Malvern, Worcestershire, and many informative papers on a variety of topics were produced, all of which provoked much discussion. This very valuable annual event promotes the exchange of ideas and reinforces the code of practise which both institutions strive to maintain during these times of continually falling standards of service in the community.

XX
Nursing Homes

Registered under the Nursing Homes (Registration) (Jersey) Law, 1950, as at 1st January, 1989

	No. of beds
Beauport Nursing Home Route des Genets St. Brelade	36
Bon Air Nursing Home Bon Air Lane St. Saviour	38
Clarkson House — Jersey Hospice Care Rue de la Haie du Puits Grouville	5
Clifton Nursing Home Bagatelle Lane St. Saviour	17
Dainhurst Health Farm Primrose Hill Bon Air Lane St. Saviour	8
Greenwood Nursing Home West Hill Mont à l'Abbé St. Helier	4
Guardian Nursing Home La Rigondaine Grouville	30
La Rocque Nursing Home Greenwood St. Clement	19
Palm Springs Nursing Home Trinity Hill St. Helier	21
Vermont Nursing Home Rue des l'Isles La Haule St. Brelade	42

Nursing homes are inspected before registration and periodically thereafter by officers of the department.

As well as the routine visiting of homes, complaints are investigated and advice provided when requested, on aspects of administration, nursing facilities, etc. The clinical care of patients in nursing homes is the responsibility of the specialist or family doctor concerned.

XXI

Residential Care Homes

Registered under the Old Persons Homes (Registration) (Jersey) Law, 1964
as at 1st January, 1989

	Maximum Number of Residents
St. Helier Community Services Board:	
St. Helier House, Westmount	62
Maison de Ville, La Pouquelaye	50
Gardner House, Clarence Road	32
St. Brelade's Parish:	
Maison St. Brelade, Petite Routes des Mielles	51
Admar, Maudelaine Estate, St. Brelade	7
Alexandre Home for the Aged, Longueville, St. Saviour	39
Caesarea Association:	
Windsor House, Val Plaisant, St. Helier	9
Cambrette, Coast Road, St. Clement	23
Chantreys, Route des Genets, St. Brelade	8
Cranworth, Vallée des Vaux, St. Helier	27
Field House, Route du Sud, La Moye, St. Brelade	12
Glanville Home for Aged and Infirm Women (Inc.), St. Mark's Road, St. Saviour	36
Glenferrie, 24 Peirson Road, St. Helier	15
La Villa Rothesay, Victoria Crescent, St. Helier	21
La Ville a l'Evèque House, Trinity	7
Les Houmets, Gorey Village, Grouville	21
Little Sisters of the Poor, Jeanne Jugan Residence, New St. John's Road, St. Helier	80
Longfields, Rue du Bocage, St. Peter	19
Methodist Home for the Aged:	
Maison La Corderie, Green Street, St. Helier	36
Stuart Court, Rue de Haut, St. Lawrence	29
Morley House, Aubin Lane, Bagot, St. Saviour	23
Seabright, Gorey Hill, St. Martin	8
Springbank, Vallée des Vaux, St. Helier	53
Tendercare Rest Home, Fauvic House, Grouville	17
White Lodge, Grosvenor Street, St. Helier	10

Residential Homes are inspected by the Medical Officer of Health before original registration and periodically thereafter by the Nursing Advisor to the Public Health Committee. They are also regularly visited by members of the Residential Homes Sub-Committee of the Public Health Committee.

As well as the routine inspections of homes, complaints are investigated and advice also provided on aspects of care, etc. The clinical care of patients in residential homes is the responsibility of the family doctor concerned.

XXII
Nursing agencies

Registered under the Nursing Agencies (Jersey) Law, 1978, as at 1st January, 1989

Apex Nursing Agency La Villa Rothesay, Victoria Crescent, St. Helier	Mr. Stephen John Beck and Mrs. Jacqueline Beck
Beauport Nursing and Home Aid Agency (1986) Ltd., Route des Genets, St. Brelade.	Beauport Nursing Home (1986) Ltd.
Clifton Home Care Services Clifton Nursing Home, Bagatelle Lane, St. Saviour.	Clifton Nursing Home Ltd.
Guardian Nursing Agency Guardian Nursing Home, La Rigondaine, Grouville.	Guardian Nursing Services Ltd.
Morley House Nursing Agency Aubin Lane, Bagot, St. Saviour.	Morley House Ltd.
Pim's Nursing Agency Fairview, Trinity.	Mrs. Pamela Mary Pim
Osborne Nursing Agency Okanagan, Le Hocq Lane, St. Clement.	Osborne Nursing Agency Ltd.

XXIII

Establishments for massage and special treatment

Registered under the Establishments for Massage or Special Treatment (Licencing) (Jersey) Law, 1938, as at 1st January, 1989

Physiotherapy

Mrs. Penelope J. Campbell	Edgecliffe, Park Estate, St. Brelade
Mr. Paul Deveney	Lido Fitness Centre, Hotel de France, St. Helier
Mr. Charles P. Hunt and Mrs. Esme Hunt	Orchard Corner, La Route du Fort, St. Helier
Mr. Keith I. S. Nicol	Physiotherapy Clinic, Dongola Road, St. Helier
Miss Diana J. Raven	Solanita, Park Estate, St. Brelade

Chiropody

Mr. Alun P. G. Bennett	6 Royal Crescent, St. Helier
Mr. Alun P. G. Bennett	The Surgery, Le Riches Stores, St. Brelade
Miss Karen J. Bille-Campbell	19 Midvale Road, St. Helier
Miss Rosemary M. S. Brown	Clovelly, 24 West Park Avenue, St. Helier
Miss Louise S. de Silva	13 David Place, St. Helier
Miss Claire D. Georgelin	Fernlea Surgery, Fauvic, Grouville
Miss Tina H. Hairon	1 Peirson Road, St. Helier
Mr. Martin L. Huelin	20 Sand Street, St. Helier
Mrs. Eunice D. Le Gresley	The Surgery, Holmside, Rue Messervy, St. Saviour

Chiropractice

Mr. Brian Bolderston	Jersey Chiropractic Clinic, 12 Hill Street, St. Helier

Sauna, Solaria etc.

D.C.T. Holdings Limited	Allandale Hotel, Rue du Becquet Vincent, Trinity
Mount Pleasant Holdings Limited	Apollo Hotel, St. Saviour's Road, St. Helier
Beachcombers Hotel Limited	Beachcombers Hotel, Grouville
Chelsea Hotel Limited	Chelsea Hotel, Gloucester Street, St. Helier
David Le Cornu Limited	Cornucopia Hotel, Mont Pinel, St. Helier
Almeida Hair Stylist Limited	Grand Hotel, Almeida Hair and Beauty Salon
Hotel Bergerac Limited	Hotel Bergerac, Portelet Bay, St. Brelade
Hotel de France Limited	Hotel de France, Lido Fitness Centre
Mrs. Jane M. Stewart	Hotel de France, "Renaissance"
La Plage Hotel Limited	Hotel de la Plage, Havre des Pas, St. Helier
Mr. Stewart F. Collings	Hotel L'Hermitage, Beaumont, St. Peter
Hotel L'Horizon Limited	Hotel L'Horizon, St. Brelade's Bay
Shield Investments Limited	Jersey Holiday Village, Portelet, St. Brelade
Delrich Hotels Limited	La Place Hotel, La Haule, St. Brelade
Laurels Hotel (1983) Limited	Laurels Hotel, Route du Fort, St. Helier
Café Casino Limited	Les Arches Hotel, St. Martin
Modern Hotels Group	Mayfair Hotel, Brooklyn Lane, St. Helier
Mermaid Hotel Co. Limited	Mermaid Hotel, St. Peter
Merton Hotel Limited	Merton Hotel, Belvedere, St. Saviour
Old Court House Hotel Limited	Old Court House Hotel, Gorey

Pontins (Jersey) Limited	Pontins Holiday Village, Plemont, St. Ouen
Royal Brees Hotel Limited	Royal Hotel, David Place, St. Helier
Royal Oak Hotel Limited	Royal Oak Hotel, Great Union Road, St. Helier
Silver Springs Hotel Limited	Silver Springs Hotel, St. Brelade
Swansons Hotel Limited	Swansons Hotel, Esplanade, St. Helier
St. Brelade's Bay Hotel Limited	St. Brelade's Bay Hotel, St. Brelade
Mrs. Joan M. Colombo	Talana Private Hotel, Bagot Road, St. Saviour
Sheldrake Investment Co. Ltd.	Water's Edge Hotel, Bouley Bay, Trinity
Westhill Hotel & Country Club Limited	Westhill Hotel, Mont à l'Abbé, St. Helier
Mrs. Diane Canavan	Sienna, Route Orange, St. Brelade
Mrs. Joyce Songhurst	Dainhurst Health Farm, Primrose Hill, Bon Air Lane, St. Saviour
Mrs. Josephine McWhinney	David Place Beauty Clinic, 17 David Place
Miss Susan Delauney	Salon Roche, Roche Banque, St. Clement
Mrs. Diana F. Mossop	Diana's Beauty Salon, 10 St. James Street
Abraham de Gruchy and Co. Limited	Dimensions' Hair and Beauty Salon, King's Arcade, King Street, St. Helier
Fort Regent Development Committee	Fort Regent Leisure Centre, St. Helier
Miss Patricia A. Simpson	Giselle, 1 Marett House, Roseville Street
Mrs. Susan J. Nichols	Heads Together, 7 Seale Street, St. Helier
Mrs. Gillian P. Mayer	Health and Beauty Salon, 7 Halkett Street, St. Helier
Mrs. Suzanne Reed	Image – Hair and Beauty Centre, 36 The Parade, St. Helier
Mr. Jamie R. Laffoley	Jamie's Hair Designs, Longueville
Miss Helen Waterson	Janelle Beauty Services, Shapers, Maison Le Riche, St. Brelade
Miss Kirsten Sand	Kirsten Sand Beauty Salon, House of Dupre, 20 Bath Street, St. Helier
Mrs. Jane M. Stewart	Matisse, St. Aubin
Mr. R. A. (Roy) MacDonald	1 Romney Villas, St. Aubin's Road, St. Helier
Mrs Karen P. Glover-Wright	Sundance Studios, 3 Francis Street, St. Helier
Miss Carol L. Begg	Sundance Beauty Room, 3 Francis Street, St. Helier
Mr. Clive Marquis and Mrs. Susan J. Marquis	Studio Soleil Health and Beauty Centre, 11 Stopford Road, St. Helier
Mrs. Joan M. Tilston	Treetops, St. Peter's Valley, St. Peter
Mrs. Julie A. Lelong and Mrs. Phyllis M. Trachy	Tanfast, 10a Beresford Street, St. Helier
York Street Stores Limited	"The Sunrooms", York Street Stores, St. Helier
Miss Nuala Sawyer	Votre Beauté, 17 Duhamel Place, St. Helier
Mrs. Michelle B. Pickett	Visagiste Hair and Beauty Salon, 1st Floor, 49 Halkett Place, St. Helier